19. WAS AUTOPSY PEREORMED? NO X (County) (State) FUNERAL DIRECTOR: Page and in my apinian Natural causes K. Accident . Suicide . Hamicide . Undetermined manner 22. DATE SIGNED Heolth prior DEPUTY MEDICAL EXAMINER X July 27, 1967 Address (Street, city, town, or coungimberland, Maryland 23b DATE THEREOE 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) REMOVAL (Specify) 7/29/67 Cumberland Allegany Maryland RoseHill Cemetery Burial 21502 24. FUNERAL DIRECTOR ¿Cinarles Judge DATE JUL 31 H.Lee Silcox Cumberland.Maryland 6M 1/67

Allegany

Doy

12. CITIZEN OF WHAT U.S.A

IF UNDER I YEAR

Months

e. IS RESIDENCE ON A FARM?

Year

IF UNDER 24 HRS

NO X

YES |

Hours

INTERVAL BETWEEN

Sudden DEATH

VR A15ME (5)

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATI PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) or your files. e. COUNTY **b.** COUNTY MARYLAND Allegany W. Va. Mineral b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate timits, write RURAL and give nearest town) write RURAL end give nearest town) 5 McCoole Keyser d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Boar 3 to the funeral Rt. 4 retained State Rt. 220 3. NAME OF First. Middla Last 4. DATE Month DECEASED DEATH (Type or print) Allamong JULY Douglas 6. COLOR OR RACE 7, MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER I YEAR) 5. SEX B. DATE OF BIRTH may 2 wig last birthdey) Months 2, and WIDOWED DIVORCED Male 16 Jan 1935 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Page dona during most of working life, even if retired) U.S.A. Paper Ind. West Virginia pages | within Analyst 13. FATHER'S NAME form PM3. 14. MOTHER'S MAIDEN NAME Gladson Allamong Beatrice Camp event IS. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yas, no, or unkown) | (Ifyesgive werordeles of service) \*\*XAMINER: This certificate should be executed water, writing the word "panding" in peacil in Item 1. Office along with Rt 4 Keyser, W. Va. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] burial-transit PART I. DEATH WAS CAUSED BY: Fractured Skull removal, and IMMEDIATE CAUSE (e) **DUE TO** (Auto-Motorcycle Accident) Conditions, if any, which d "panding" i geve rise to immediate cause m DUE TO (a), sleting the underlying SE pesn PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4)1 19. WAS AUTOPSY CERTIFICATION 8 certificate, writing the word plnods 20e, EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) PRIMARY [ ] or CONTRIBUTING [ Briver of Motorcycle involved in accident Chief age 3 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, | 20f. (City or town) 20c. TIME OF INJURY (County) Month, Dey, Year fectory, street, office bldg., etc.) McCoole, Allegany, te #220, I mile north Keyser. While el work | el work & Route #220, 1967 50 H 23. I certify that I took charge of the remains described above, held an Autopsy X). Inspection X. Inquiry X forwarded to Accident X. Suicide Homicide Undetermined manner death resulted from: Natural causes CHIEF MEDICAL EXAMINER please execute him 4 should be forward PUNERAL DIFF or its designated a ACTUAL **经关系外区外区区区区区域的** SIGNATURE DEPUTY MEDICAL EXAMINER XX July 23, 1967 DEPUTY Address (Street, city, town, or count Cumberland, Maryland BENEDICT SKITARELIC. M.D. NAME (Type) 22c. NAME OF CEMETERY OR CREMATORY 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or country) REMOVAL (Specify) July 67 Potomac Valley Park Keyser, 24e. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR ADDRESS

Keyser, W. Va.

. IS RESIDENCE

YES NO K

19 67

IF UNDER 24 HRS.

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

(State)

Maryland

YES XX NO

and in my opinion

DATE SIGNED

(Slele)

W. Va.

Minutes

Year

Day

Days

ON A FARM?

VS. AISME SM 9/60

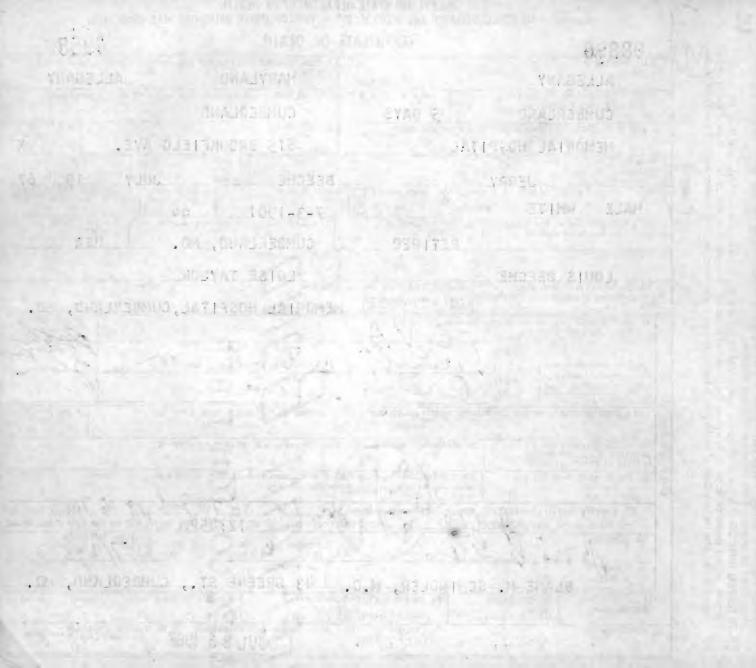
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quarters. 2010101 +1740 -124 and the line of the later of th 21 22 72 72 T. SHERRY - 2 CEASING THE PROPERTY AND A PARTY IN A PARTY Ananinan to avieval amedates As navina TO THE THE PARTY OF THE PARTY O majar property of the state of 

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY ALLEGANY ALLEGANY 24 hours after MARYLAND von papers. Pages I within 72 haurs after attending physician and completely filled in by the sourmit. Then please remave carbon papers. Pages b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) DAYS CUMBERLAND e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS MEMORIAL HOSPITAL 815 BROOKFIELD AVE. YES NOX requires that the death certificate be executed within NAME OF DATE DECEASED (Type or print) **JERRY** BEECHE DEATH and in onv events 9. AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS B. DATE OF BIRTH SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months lost birthdoy) Days Hours WHITE WIDOWED MALE DIVORCED 7-3-1901 10b. KIND OF BUSINESS OR 11, BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) INDUSTRY USA CUMBERLAND, MD.

14. MOTHER'S MAIDEN NAME RETIRED 13. FATHER'S NAME or remayal, LOUIS BEECHE LOISE TAYLOR 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service 214-05-9413 MEMORIAL HOSPITAL CUMBERLAND. INTERVAL BETWEE 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY burial-transit IMMEDIATE CAUSE (o) physician. DUE TO signed Conditions, if any, which gave rise to immediate couse (a) DUE TO stating the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been PHYSICIAN: The law last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use CERTIFICATION State Dept. of Health NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Haur o.m factory, street, affice bldg., etc.) Not While et work ot work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 12 . LAS par causes and on the date stated above. saw the deceased alive an 22o, SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. PHYS. PHYS. director, page should be filed 22d. ADDRESS 22c. PHYSIC AX NAME (Type GREENE ST. CUMBERLAND. SCHINDLER 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify) Restlawn Memorial Park Near Cumberland Md 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Scarpelli, Cumberland, Md. VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY ALLEGANY MARYLAND ALLEGANY c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYS CUMBERLAND d. STREET ADDRESS e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARMS 408 MARYLAND MEMORIAL HOSPITAL bone and NO NAME OF First Middle 4. DATE Lost Month Year DECEASED JULY BLAIR 67 WILLIAM 19 DEATH (Type or print) 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remove Months WHITE MALE WIDOWED DIVORCED 8-11-1893 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life even if setired S.T.CO. W. VA. 14. MOTHER'S MAIDEN NAME JENNIE STEWARD 13. FATHER'S NAME JOHN BLAIR 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) WW HOSPITAL . WUMBERLAND. 18. CAUSE OF DEATH (Enter only one couse per-line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate cause (o), DUF TO stating the underlying cause the hos been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO V O FUNERAL DIRECTOR: After this certificate for 20o. ACCIDENT WAS UNDERLYING 05 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) of work of work 21. I certify that (1) (this hospital) attended the deceased from 200 26. 196 , and that death occurred at \$ 45 Morrom cours and an the date stated above. saw the deceosed alive on 22o. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 122 S. CENTRE ST., CUMBERLAND, MD D.B. GROVE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) BURIAL (Specify) CUMBERLAND, MD. JULY 4,1967 SUNSET MEMORIAL PARK 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR BYRON KIGHT CUMBERLAND, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

CARROLL TO THE MANAGEMENT OF THE STATE OF TH THE THE THE THE THE - M. H. 386-85-85 JATHAR IS JATAS SA THE WAY THE SALES 91.029 E 2001-11.9 3.10 . Value of the Yarish contribution . Transport of the state of the 

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EYAMINED'S CEDTICICATE OF DEATH necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page the frete Deportment of a 72 havrs after death.

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	PLACE OF DEATH	1 -				2. USUAL RESIDENCE	(Where deceas	ed lived, if institut				n)	
	a. COUNTY	7		MARY	LAND	a. STATE	han d	b. COU		3			
	b. CITY OR TOWN (	legany If outside corporate li	mits	. LENGTH OF STAY II		c CITY OR TOWN (IF o	rland	to limite maito PII		Legar			
	write RURAL one	d give neorest town)	11113,	C. CENOMI OF SIAT II	1 10	4		ie inilis, wille ku	KME ONG GIS	e neuresi	TORVITY		
Cumberland  I.ife d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)					Cumberland 0//								
1						d. STREET ADDRESS	-				ON A FA	ENCE RM2	
		al Hospi	talD	OA	+	414 Par	k Str	eet		1	YES 🗌		
	NAME OF DECEASED		First.	Middle		Lost	4. DATE	Mon		Day			
	(Type of print)	HAF	WEY	С.	BRA	LITHWAITE	OF DEATH	July	y	4,	1967	7	
S.	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED		B. DATE OF BIRTH	9	AGE (In years	IF UNDER		IF UNDER		
2	Male	White	. MIDOMED	DIVORCED	X A	pril 20,	1893	last birthday)	Manths	Doys	Hours	Min.	
10a	USUAL OCCUPATION	(Give kind of work do	ne 10b. KI	ND OF BUSINESS OR		11. BIRTHPLACE (State	e ar fareign ca	untry)		TIZEN OF			
dur	ng most of working Railroa	lite, even it retired)	B. 18	& O. Rai	lroa	d Virgi	nia		1 4	MULES 3	A.		
	FATHER'S NAME	a				14. MOTHER'S MAIDEN			1				
	Jackson	Braith	aite			Ida Sto	tler						
15.	WAS DECEASED EVE	R IN U.S. ARMED FORCE	5? 16. 5	OCIAL SECURITY NO.	17.	INFORMANT		Addre	255				
(78	No	(If yes give wor or dot	70	5-10-3953	3 Mi	s. Guy Sm	eight	Mar	tinsk	urg	.W.	Va.	
		ATH (Enter anly one									RVAL BETV		
	PART I. DEATH WAS CAUSED BY:										당생아		
	La 1/1 Immediate Choice (v)												
	Conditions, if any, which gove ) (b) Coronary Sclerosis												
	rise to immediate couse (a)												
	stating the underlying cause DUE TO												
	last. (c)												
NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED?												
MEDICAL CERTIFICATION										20		NO X	
TIE	20g. EXTERNAL CA PRIMARY ☐ gr COI		20b. DES	CRIBE HOW INJURY OC	CURRED.	(Enter nature of injury in	Part I ar Part	Il of item 18.)					
CER	CAUSE OF DEATH.	MINIDUING L.J											
2	20c. TIME OF INJU	JRY Month, Day, Year	20d IN	JURY OCCURRED		CE OF INJURY (Hame, far		(City ar town)	(Co	unty)	(5	state)	
MED	Hour a.n		9 While at wark	Nat While at wark	fac	tary, street, affice bldg., etc	.)						
	21. I certify that I took charge of the remains described abave, held on Autopsy , Inspection to Inquiry. Inquiry.												
	death resulted fram: Notural couses K., Accident J., Suicide J., Hamicide J. Undetermined monner												
	CHIEF MEDICAL EXAMINER												
	ACTUAL / 2 DATE SIGNED												
	SIGNATURE M.D. ASSISTANT INCIDENCE EXAMINER TO												
	EXAMINER'S NAME (Type)	Banadia	+ 91-1+	arelic. 1	rn	Address (Stree	et city town	or countimbe	7 49	770	TATA .		
230	BURIAL, CREMATIC			23c. NAME OF CEME	FRY OP	CREMATORY	7 234 10	CATION (City or To	mu/	(County)	150	ate)	
200	REMOVAL (Specify, Burial		8.1967					acre-F		cick	Co		
24	FUNERAL DIRECTO		0,2001	ADDRESS		25a. REC						-	
L-4.		G, Kight	C	umberland,	Ma-	34	JULI	1967	GISTEAR'S S	rea	Your	SL.	
	11 - T T T STIT	A WIRIII	U	miner Tang	LICLO	DATE			U		11	7	

VR A15ME (5)

5 may be retained far yaur files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health or its designated agent, priar ta burial, crematian, ar remaval, and in any event with

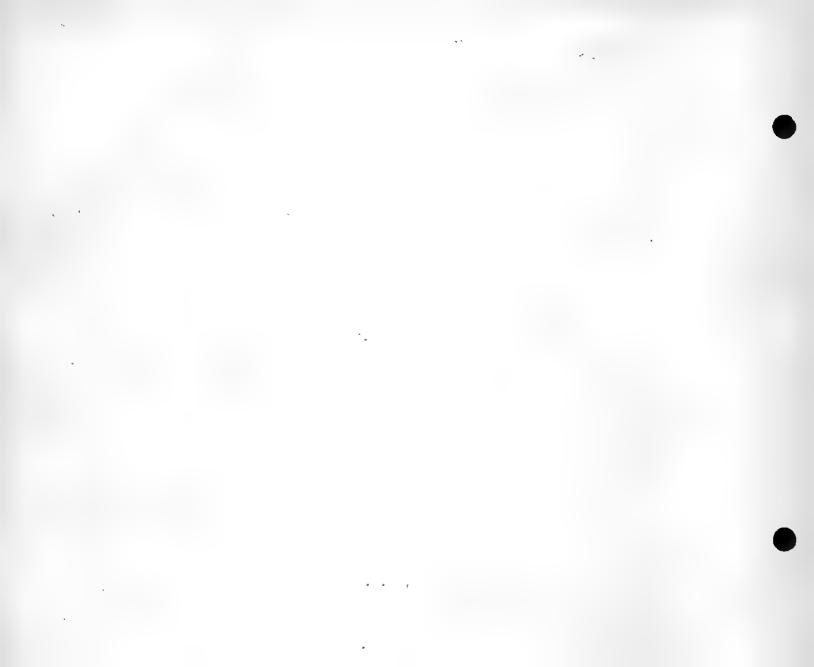
This certificate shauld be executed within 24 haurs after death. If

necessary, please execute the certificate, writing the ward

TO DEPUTY MESTAL EXAMINER:

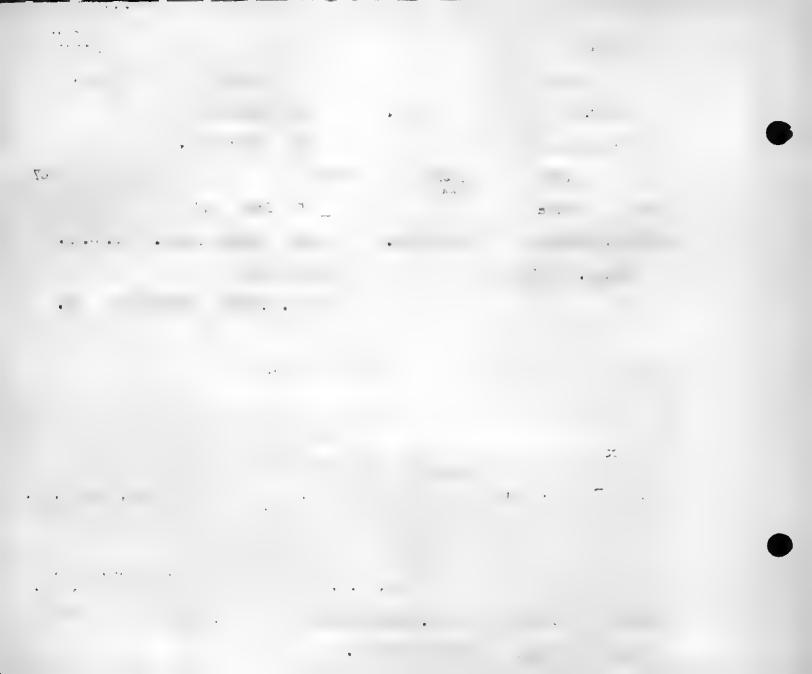
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased ( ved. f institution. Residence before admission) o COUNTY b. COUNTY Allegany 2, and 3 to PM3. Page o STATE Maryland Allegany MARYLAND delay i b CTY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN In 65 years Cumberland e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) d. STREET ADDRESS ward "pending" in pencil in Item 18 Give Pages 1, the Chief Medical Examiner's Office along with farm Route 4 Oldtown Road Memorial Hospital ate. YES NO PX 24 haurs after death. 3 NAME OF Lost 4 DATE Month Doy Year within 72 DECEASED 19 67 July Benjamin Sanford Brake (Type or print) DEATH S SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR F UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED st birthdoy) Months Dovs Hours Nov.3,1885  $\mathbf{x}$ White WIDOWED DIVORCED Male event 11. BIRTHPLACE (State or foreign country) 10p USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired)
Retired Enzineer INDUSTRY. USA French Creek.W. Va. road dny. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME This certificate shauld be executed within c Mary Hartman Isaac W. Brake pup IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT .6 SOCIAL SECURITY NO. 15 WAS DECEASED LYEK IN U.S. ARMED TO GOES of Service) 705-07-6846 remayal, William R. Brake. Cumberland. Md.-Son INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) PART I. DEATH WAS CAUSED BY TONSET AND DEATH Uremia Ġ IMMEDIATE CAUSE (o) crematian, DUE TO Hypernephroma of Kidney Conditions if any, which gave be farwarded to rise to immediate couse (a), DUF TO stoting the underlying couse lost. burial, PART I., OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? please execute the certificate, YES XX NO Health ar its designated agent, priar to 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of nurry in Part 1 or Port II of Item 18.) PRIMARY I or CONTRIBUTING I shauld CAUSE OF DEATH. 20c TIME OF INJURY Month, Day, Year 20d NJURY OCCURRED 20e PLACE OF INJURY (home farm, (City or fown) (County) (State) Hour om. Not While foctory, street, office bldg , etc.) at work Inquiry DCK 21. I certify that I took charge of the remains described above, held an Autapsy [7]. Inspection ICA and in my apinian Natural causes 1 Accident Suicide 🗍 the funeral directar. death resulted fram: Homicide | Undetermined manner retained CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER may be re FUNERAL I **SIGNATURE** JULY 23. 1967 DEPUTY MEDICAL EXAMINER **EXAMINER'S** SKITARELIC, M.D. BENEDICT Address (Street, city, town, or countyMBERLAND, MARYLAND NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL CREMATION. (County) 0 REMOVAL (Specify) July 26.1967 Cumberland, Md. Allegany Hillcrest Burial Park Burial 250 RECD BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME James F. Scarpelli, Cumberland, Md. 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08893 CERTIFICATE OF DEATH death. guo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE Allegany MARYLAND Maryland Allegany law requires that the death certificate be executed within 24 hours after physician and completely filled in by the b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c EITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) bon popers. Page write RURAL and give nearest tawn) Frostburg | 1 wee
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitor, give street oddress) Mt. Savage R.D.#1 l week d. STREET ADORESS # IS RESIDENCE ON-A FARM? Miners Hospital NO pou 3 NAME OF Middle Lost 4. DATE Month Day Year DECEASED (Type or print) ÖEATH Elmer R Bridges F UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** 8 DATE OF BIRTH AGE (In years lost birthdoy) Ove Coys Months Hours WIDOWED White DIVORCED Male 22 Mav 66 yrs 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) please COUNTRY? during most of working life, even if retired) INDUSTRY Refractory worker Refractory. Allegany Mary land 13. FATHER'S NAME en en Abraham Bridges Rosetta Diehl 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) No 220-03-7173Mrs.Leona E. Bridges Mt. Savage Md. INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) signed by the burial-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) OUF TO Conditions, if any, which gove rise to immediate couse (a). OUF TO stating the underlying couse os the O FUNERAL DIRECTOR: After this certificate hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING O DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMEO? Heolth p NO P YES | far 200 ACCIDENT WAS UNDERLYING 205. OESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) Hour o.m. foctory, street, office bldg., etc.) Not While + at work 21. I certify that (I) (this haspital) attended the deceased fram Occurred at 71:35 M, from causes and on the date stated above. TO HOSPITAL OR ATTEND Poge 4 moy be retained 22n SIGNATURE 22b DATE SIGNED M.D. **OIRECTOR** PHYS. r, poge 3 be filed PHYS 22d. AODRESS 22c PHYSICIAN NAME (Type) Strong Main St. Frostburg Md Bast director, should b 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify) 12.1967 Rest Lawn Mem. LaVale Park Allegany Ma 60 West Main St. Ffostburg RAMA VR A15 (4) 20 M 1/66 MontesautHafer-SowersFuneralHoment

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
PLACE OF DEATH										
ALLEGANY MARYLAND MARYLAND										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town CUMBERLAND  c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town CUMBERLAND)										
£ / /										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  MEMORIAL HOSPITAL  o. Is resident on a farm  yes \sum no \( \bigcircle{1} \)										
3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED (Type or print) JOHN CASPER BRINKER DEATH 7. 24 167										
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR) IFUNDER 24 HI Jast birthday) Months   Days   Hours   Mil										
MALE WIDOWED DIVORCED 25 7 1073 74 yrs.										
10e. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired)  ROOF ING CONTRACTOR  10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.  11. BIRTHPLACE (State or foreign country) SHARON. PENNA.  12. CITIZEN OF WHAT COUNTRY?  COUNTRY?  U. S. A.										
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME										
JOHN A. BRINKER MARY POWERS										
15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address (Yes, no. or unknown)   (If yes alre was or dates of service)										
RITA E. BRINKER CUMBERLAND MD.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]  PART I. DEATH WAS CAUSED BY:  Shock  Shock										
IMMEDIATE CAUSE (d)										
Conditions, if eny, which (b) Multiple Fractures ff										
gave rise to immediate ( cause (s), stating the DUE TO										
underlying couse lest. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO  20a. EXTERNAL CAUSE WAS PRIMARY BOT CONTRIBUTING CONTRIBUTING CAUSE OF DEATH.  EVALUATE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Port II of Item 18.) FELL from roof of 2 story house										
YES NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nuture of Injury in Part I or Pert II of Item 18.)										
20a. EXTERNAL CAUSE WAS PRIMARY D or CONTRIBUTING CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Pert II of Item 18.)  Fell from roof of 2 story house										
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF NJURY (home, farm, 20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy XX. inspection XX. Inquiry XXI, and in my opinion										
death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner										
ACTUAL SIGNATURE DELLA SKITATE LIZ M.D. ASSISTANT MEDICAL EXAMINER [ 22. DATE SIGNE										
DEPUTY MEDICAL EXAMINER X1 July 24, 1967										
EXAMINER'S BENEDICT SKITARELIC, M.D. Address (Street, city, town, or counting berland, Md.  23a. BURIAL, GREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OF CREMATORY   23d. LOCATION (City, town or county) (State)										
23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)  BURIAL JULY 27 1967 ST. MARYS CEMETERY CUMBERIAND MARYLAND										
24. FUNERAL DIRECTOR ADDRESS   25a. REC'D BY REG.STRAR 25b. REGISTRAR'S SIGNATURE										
LOUIS STEIN INC. CUMBERLAND MD. DATE AUG 1 1967 CHAPLES JUSTE										



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03885 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) · CANTEEGANY o STATE b. COUNTY ALLEGANY MARYLAND ician and completely filled in by the lease remove rathon popers. Pages and in any event, within 72 hours aft b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate simits, write RURAL and give nearest town) write RURAL and give nearest town) CUMBERLAND 44 DAYS CUMBERLAND d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? SACRED HEART HOSPITAL-CUMB., MD. 806 MICHIGAN AVE., CUMB., MD. NO D NAME OF Middle 4. DATE Lost Month Dov Year DECEASED MABEL Beatrice BROWNING 1967 JULY 24 (Type or print) DEATH S. SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS 7. MARRIED NEVER MARRIED B DATE OF BIRTH birthday) FEMALE WHITE AUG.,9, 1900 WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired INDUSTRY COUNTRY ? CUMBERLAND-ALLEGANY-MD USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal, JOHN MILLESON SALLY (HAINES) 17 INFORMANT 15 WAS DECEASED EVER IN 3 S ARMED FORCES? 16. SOCIAL SECURITY ND Address (Yes, no, grupknown) (If yes give war or dates of service 705-09-6677 HOSPITAL CHART-SACRED HEART HOSPITAL INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line "(a), (b), and (c) signed by the buriol-tronsit PART 1. DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove nse to immediate couse (a), DUE TO stating the underlying couse WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20s. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While of work 21. I certify that (I) (this hospital) attended the deceased from Page 4 moy be retained M. from causes and on the date stoted obove saw the deceased anve on\_ and trat death occurred at 220 SIGNATURE ATTENDING STAFF PHYS. M.D DIRECTOR 22d ADDRESS M. SCHINDLER, M.D. BLANE GREENE ST .. CUMB . O FUNERAL NAME (Type) director, should be 23d LOCATION (City of Town) DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY 23o. BURIAL CREMATION (County) REMOVAL (Specify) 7/26/67 Cumberland Allegany Maryland Hillcrest Burial Park 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR SILCOX FUNERAL HOME H. Lee Silcox 404 DECATUR ST. CUMB. MD

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08898 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. signed by the attending physician and campletely filled a by the funeral burial-transit permit. Then please remove carban popers. Pages I and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. COUNTALLegany o. COUNTY Allegany MARYLAND b CITY OR TOWN (If outside corporate limits c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Frostburg Rural Rt. Frostburg, Rural Rt. d NAME OF HOSPITA. OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS o IS RESIDENCE ON A FARM? NO DE YES With 4. DATE OF 3 NAME OF Middle Doy Year First DECEASED RAYMOND H. BUCKALEW 28/1967 19 (Type or prent) DEATH IF UNDER 1 YEAR IF JNDER 24 HRS AGE (In years 6 COLOR OR RACE DATE OF BIRTH 7 MARRIED A NEVER MARRIED birthdoy) Hours Male White 7/1903 WIDOWED DIVORCED 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most norking life, even if retired) **ENDUSTRY** USA ? Midlothian. Md. 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME George Buckalew Grace Wilson 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCE 57 16 SOCIAL SECURITY NO (Yes, no Nymknown) [If yes give wor or dotes af service Mrs. Mary Buckalew, Midland, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO as the prior tal stoting the underlying couse this certificate has been last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO A 205. DESCRIBE YOW INJURY OCCURRED. (Enter notule of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING ... OR CONTRIBUTING [ ] CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a.m Not While foctory, street, office bldg., etc.) TO FUNERAL DIRECTOR: After be retained by 2]. I certify that (I) (this haspital) attended the deceased from and 15 6. to. 19 67, and that death accurred ot/0/5 AM, from causes and an the date stated above saw the deceased alive an **DATE SIGNED** 220 SIGNATURE MED. DIRECTOR STAFF PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Paige Strong M.D. Frostburg, Md. directar, shauld 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify) 1967 St. Josephs Cemetery Midland. Burial
24. FUNERAL DIRECTOR \_2Sb. REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 20 M 1/66 George Eichhorn Lonaconing, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) and completely filled in by the funera O. STATE MARYLAND o. COUNTY b. COUNTY ALLEGANY ALLEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 19 DAYS MT. SAVAGE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? MINERS HOSPITAL YES NO X NAME OF First Middle Lost 4 DATE Month Dov carbon DECEASED **GLENDORA** BURCH EVA DEATH JULY 18. 1967 (Type or print) gvent, SEX 9 AGE (In years IF UNDER 1 YEAR 1 IF UNDER 24 HRS. 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH NEVER MARRIED remove Months lost birthdoy) Dovs Hours in any PEMALE WHITE WIDOWED DIVORCED JUNE 22, 1905 100 USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 12 CHIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) KELLY-S. COUNTRY? please during most of working the even if retired) U.S.A TIRE CO. MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME RTCHARD UHL ALICE HOLTZMAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dates of service) 213-22-3402 CHARLES BURCH, MT. SAVAGE, MD. BOX 443 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (p). DUE TO stoting the underlying couse the lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO K YES [ O FUNERAL DIRECTOR: After this certificate 5 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH etoched f Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this hospital) attended the deceased from June 29, 44719. , 1967, that (I) (we) lost 18 19 62, and that death occurred at 8 40 M, from couses and on the date stated above. sow the deceased alive on. 22o. SIGNATURE 22b. DAJE SIGNED M.D PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN A. PAIGE STRONG. M. D. E. MAIN ST., FROSTBURG, MD. NAME (Type) director, should b 23o. BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) BOM Ah (Specify) JULY 20, 1967 METHODIST CEMETERY MT. SAVAGE, MD. 250. REC'D BY REGISTRAR **ADDRESS** 2Sb. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) JOSEPH R. DURST, SR., FROSTBURG, MD.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whata discussed livid, If institution, Residence before admission) a. COUNTY e. STATE **b.** COUNTY Maryland Allegany Allegany MARYLAND b. CITY OR TOWN (if outside corporete limits, E. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town years Cumberland Cumberland d NAME OF HOSP TAL OR INSTITUTION (if not in hosp ta g ve street address) A STREET ADDRESS . IS RESIDENCE ON A FARM? 506 Pennsylvania Avenue 506 Pennsylvania Avenue YES NO X 3. NAME OF Middle Last 4. DATE DECEASED OF (Type or print) DEATH 67 July 19 Franklin Cage 5. SEX 6. COLOR OR RACE / MARRIED NEVER MARRIED B. DATE OF BRITH AGE (In years | IF UNDER 1 YEAR! IF UNDER 24 HRS. last birthday) Months | Days Male White DIVORCED | Oct. 15. I WIDOWED within 24 hours after 18. Give Pages 1, 2, at h form PM3. Page 5 n mit. File pages 1 and 2 10b. KIND OF BUSINESS OR INDUSTRY 1) BIRTHPLACE (State or fore on country) 10e. USUAL OCCUPATION [Give kind of work 1 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, avan if ratired) Cumberland . Md. USA Railroad Retired Conductor 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Anna V. Williams Charles Cage 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO.: 17, INFORMANT Address (Yas, no, or unkown) | (Ifyesgive werer datesof service) Mrs. Pearl Cage. Cumberland, Md.-"ife 71.0 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN Sudden PART I. DEATH WAS CAUSED BY: Coronary Occlusion IMMEDIATE CAUSE (a) T 0617 DUE TO Coronary Sclerosis Conditions, if any, which' gave risa to immadiate causa DUE TO (e), stating the underlying PART II. OTHER S ON FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART 1(a): 19, WAS AUTORSY CERTIFICATION PERFORMED? NO 206. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Entar natura of injury in Pert I or Pert II of Itam 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f, [City or town) (County) (Stata) factory, street, office bldg , etc.) While Not While Hour simi at work at work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection X Inquiry X and in my opinion Natural causes Accident Suicide death resulted from: Homicide | Undetermined manner [ CHIEF MEDICAL EXAMINER ACTUAL 4 should be for CO FUNERAL. Health or its d ASSISTANT MEDICAL EXAMINER 6.45, 1019 (2.10) 1.102 (2.10) SIGNATURE DEPUTY MEDICAL EXAMINER July EXAMINER'S SKITAR FIG, M.D. Address (Street, cly town, or county umberland, Maryland P N'LDICT NAME (Typa) 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION [City, town, or country] 22a, BURIAL, CREMATION, | 22b DATE HEREOF Burial (Spac fy) Hillcrest Eurial Park Cumberland, Md. Allegany July 29,1967 ADDRESS 240 REC D BY REG STRAR | 24b, REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR -Cumberland, Md. James F · Scarpelli

MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08898 CERTIFICATE OF DEATH 28300 PLACE OF DEATH LLEGANY 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE **b** COUNTY MARYLAND ALLEGANY MARYLAND requires that the death certificate be executed within 24 hours ofter papers. Pages In 72 hours afte the c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits. write RURAL and give neorest tawn) DAYS CUMBERLAND CUMBERLAND d. STREET ADDRESS e IS RESIDENCE ON A FARM?  $\subseteq$ d NAME OF HOSP TAL OR INSTITUTION (If not in baspital, give street address) campletely filled MEMORIAL HOSPITAL 19 W. FIRST ST. NO X YES NAME OF Middle 4. DATE T.M Manth Lost Doy Year DECEASED LESSIE CAMPBELL 1967 7-10 (Type or print) DEATH IF UNDER 24 HRS. 5 SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER TYEAR 7. MARRIED **NEVER MARRIED** remove last, birthday) Months Days Hours FEMALE WHITE 6-20-94 in any WIDOWED DIVORCED 11. BIRTHPEACE (Cau 'y & State, or fareign country) 10a USBAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT please during mast of working life, even if retired) INDUSTRY Own physician ( nen please VIRGINIA COUNTY Home 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remaval, RALIEGH PITZER ZEDA MARTIN the attending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates af service MEMORIAL HOSPITAL. CUMBERLAND. MD. 220-38-0252 crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse by the haspital ar attending **DIRECTOR:** After this certificate has been the lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Health p CERTIFICATION YES [ NO 200 ACCIDENT WAS UNDERLYING [] DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detache 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While ATTENDING of work 19 8:36 21. I certify that (1) (this haspital) attended the deceased from P.M. 19\_\_\_\_, that (1) (we) last be retained saw the deceased alive an 7, and that death accurred at M, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING M.D. PHYS DIRECTOR , page be filed CUMBERLAND, 22d. 22c. PHYSICIAN'S TO HOSPITAL Page 4 may TO IUNERAL **DROSS** MD. NAME (Type) directar, shavid ! Allegany 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 23o. BURIAL, CREMATION (County) REMOVAL (Specify) Cumberland, Md. Restlawn Memorial Park 24. FUNERAL DIRECTOR Scarpelli, Cumberland, Md. VR A15 (4) 20 M 1/66 DATE

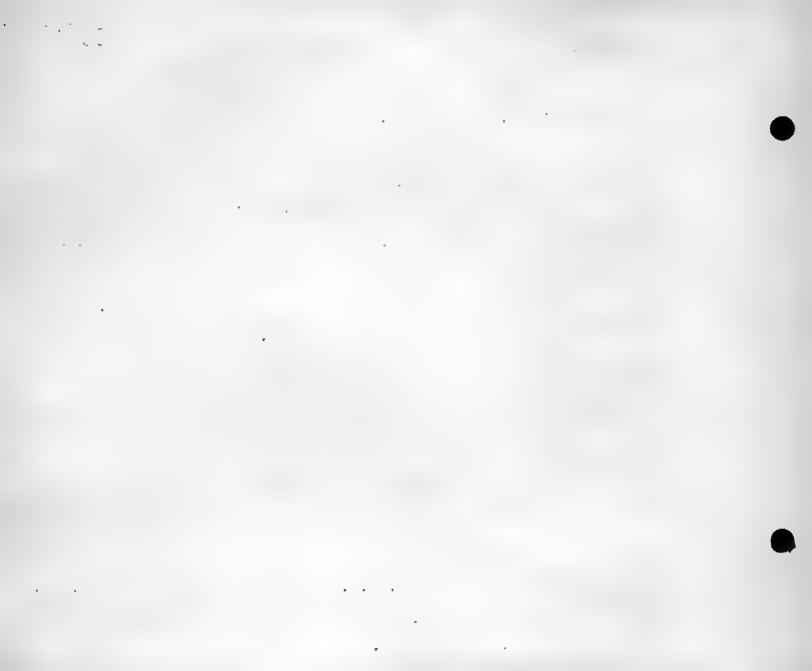
MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased livid, If institution, Residence before edimission) . COUNTY Allegany director. Pag or your files. Allegany Maryland MARYLAND b. CITY OR TOWN of outside corporate limits c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate I m ts, write RURAL and give neerest town) write RURAL end give nearest town] Cumberland-La Vale Cumberland 51 years NAME OF HOSPITAL OR INSTITUTION (I not in hospital give street address' d STREET ADDRESS IS RESIDENCE ON A FARM? State 609 Greene St. 27 National Highway YES NO EX NAME OF Midale 4. DATE Last Month Day Yeer DECEASED Gertrude Type or print) Claire Clancey DEATH July 26 6. COLOR OR RACE 17. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9 AGE (In yeers | IF UNDER 1 YEAR) F UNDER 24 HRS. lest birthdey) Months Days Hours 1 within 24 hours after d 18, Give Pages 1, 2, and h form PM3. Page 5 mi mit, File pages 1 and 2. July 11, 1916 WIDOWED DIVORCED 1, 2, a 10a. USUAL OCCUPATION (Give kind of work | 10b. KIND OF BUSINESS OR NDUSTRY 11 BIRTHPLACE (State or fore an country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Cumberland, Md. Railroad USA Clerk 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Lucy Reilley John Clancey 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO.: 17. INFORMANT Address (Yes, no, or unkown) [ (If yes give wer or detex of service) Mr. John B. Clancey, Cumberland, Md. Brother 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c) ] INTERVAL BETWEEN Sudden PART I, DEATH WAS CAUSED BY-Pulmonary Embolism IMMEDIATE CAUSE (e) " in pend Office al burial-tra DUE TO (origin deep vessels left leg) Conditions, if eny, which gave rise to immediate cause DUE TO (e), steting the underlying PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(6) 19, WAS AUTOPSY CERTIFICATION PERFORMED? YES X NO 208. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) PRIMARY | or CONTRIBUTING | writing to Chief A Page 3 sl CAUSE OF DEATH. CAL 20c. TIME OF INJURY Month, Day, Year , 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Home, ferm, ' 20f. (City or town) (County) (Slala) factory, straet, office bldg., etc.) While Not While at work et work 21. I certify that I took charge of the remains described above, held an Autopsy (X). Inspection (X). Inquiry [X] and in my opinion Natural causes X. death resulted from: Accident , Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER please exe 4 should be for FO FUNERAL I Health or its d ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATU DEPUTY MEDICAL EXAMINER F July 26, 1967 Address (Street, city, town, or countyumberland, Md. BENEDICT SKITARELIC, M.D. NAME (Typa) 220 BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) REMOVAL (Specify) St. Mary's Cemetery Cumberland, Md. Allegany Burial 23. FUNERAL DIRECTOR ADDRESS. 248 REC'D BY REG STRAR | 24b. REGISTRAR'S SIGNATURE VR A15ME James F. Scarpelli, Cumberland, Md. 5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) p. COUNTY 3 to Poge o. STATE b. COUNTY ALLEGANY MARYLAND 2 ALLEGANY MARY, AND b CITY OR TOWN (If outside corporate lam ts. c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town) write RURA, and give nearest town) ter CUMBERLAND, RT. 2 5 MOS. FROSTBURG d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) d STREET ADDRESS e IS RESIDENCI form hopfrs ON A FARM? GUNTER HOTEL NO X Give Pages ote Office olong with 3. NAME OF Middle First + Last 4. DATE Manth Year within 72 DECEASED JULY 5, 1967 (Type or print) JAMES CLARK 0. DEATH with S SEX IF UNDER 1 YEAR 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthday) Haurs MALE WHITE APRIL 29, 11894 WIDOWED I hours DIVORCED event 10a US\_ALOCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or toreign country) 12 CITIZEN OF WHAT U.S.A. during most of working the even free red)
RETIRED JANITOR MARYLAND BLDG. duy Examiner's 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME within Ξ JOHN W. CLARK ANNIE VAUGHAN puo IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOC AL SECURITY NO 17 INFORMANT be executed Address Chief Medical (Yes, no prynknawn) (If yes give war or dates at service) removol 212-18-1189 ROY F. ATHEY, CUMBERLAND, MD. RT. 2, BOX 144 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. ONSET AND DEATH CORONARY OCCLUSION cremotian, or IMMEDIATE CAUSE (o) This certificate should writing the word DHE TO Conditions, if any, which gave CORONARY SCLEROSTS rise to immediate cause (a). DUE TO stating the underlying couse used as buriol, c lost PART II. OTHER S.GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(g) 19 WAS AUTOPSY PERFORMED? NO X 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (Caunty) (State) of work Not While Haur a.m. factory, street, affice bldg., etc.) may be retoined for your FUNERAL DIRECTOR: Poge 2) I certify that I took charge of the remains described above, held an Autapsy ..., Inspection (x), Inau ry Vy and in my opinion death resulted from. Natural causes \*\* Accident ... Suicide . Hamicide | Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE X 1200 O DEPUTY DEPUTY MEDICAL EXAMINER TX July 5. 1967 **EXAMINER'S** Benedict Skitarelic, M.D. 5 may 100 FUNE Address (Street, city town, or countyCumberland. Md. NAME (Type) 230 BUR AL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) (County) (State) BUENWAYAL (Specify) JULY 8, 1967 ST. MICHAEL'S CEMETERY FROSTBURG. MD. 24, FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 25b. REGISTRAR S SIGNATURE VR A15ME (5 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08902 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. death. Pages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY ALL EGANY a STATE b COUNTY MARYLAND ALLEGANY MARYLAND c LENGTH OF STAY IN 16 popers. Page b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL DAYS 1. CUMBERLAND. MD. d NAME OF HOSPITAL OR INSTITUT ON (If not in hospitor, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled MEMORIAL HOSPITAL YES NO X 3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED FLOYD G. CLITES JULY 25 67 (Type or print) 19 DEATH S. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IE LINDER 24 HRS WHITE lost & widoy) MAI E 9-22-97 Months Doys Hours and in any WIDOWED DIVORCED puo 105. KIND OF BUSINESS OR 10e USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) physician ( ien please INDUSTRY COUNTRY? PENNSYLVANIA U.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. CHARLES S. CLITES OLLIE LOGSDON ottending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Ves 100 or unknown) (If yes give wor or dotes of service) 214--07-0216 CUMBERLAND, MD. MEMORIAL HOSPITAL cremation, INTERVAL RETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (e), (b), and (c)) signed by the burial-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY: rcinoma IMMEDIATE CAUSE (a) DUE TO unawers all Pulmoney burial, Canditians, if any, which gove (b) rise to immediate cause (a). DUE TO stating the underlying couse os the prior to l the hospital or attending 19 WAS AUTOPSY PERFORMED? hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) K KICATION State Dept. of Health ficate YES NO K 5 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH certif detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m factory, street, office bldg., etc.) Not While OR ATTENDING ot work of work Page 4 may be retained by 22 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from Huly 24 1967, and that death accurred m. from causes and on the date stated above. sow the deceased olive an FUNERAL DIRECTOR: 22b. DATE SIGNED 22a SIGNATURE MED: DIRECTOR **ATTENDING** X director, page 3 should be filed v M.D PHYS 22d. ADDRESS CUMBERLAND, MD. 22c. PHYSICIAN'S O HOSPITAL NAME (Type) DR. W. IAMES 230 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) BREMOVAL Specify) July 28. Hyndman RD#1 1967 Porter Cemetery 0 24 FUNERAL DIRECTOR 250. REC'D BY REGISTRAR VR A15 (4) Hyndman. PA.



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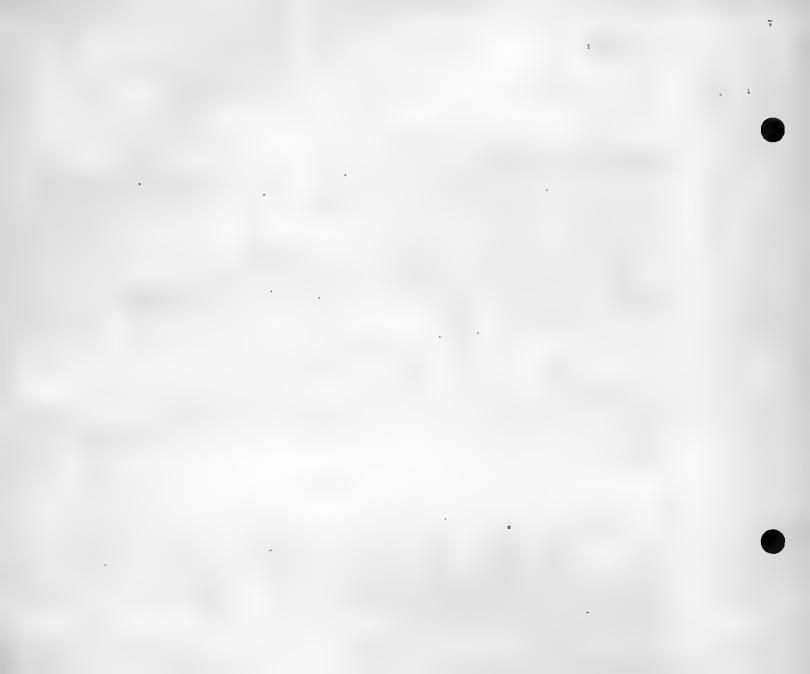
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 08305 HEALTH DEPT PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution. Residence before odmission) a COUNTY 3 to Page o. STATE b. COUNTY Allegany MARYLAND Maryland Allegany c CITY OR TOWN (If outside corporate imits, write RURAL det and an annual land b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) C LENGTH OF STAY IN 16 P.M3. F ofter Cumberland Bewmans Addition Rurial d NAME OF HOSP TAL OR INSTITUTION (if not in hosp to: give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? hours YES NO X ote Memorieal Hospital-DOA Give Pages Bowmans Addition death with NAME OF Middle 4 DATE Lost within 72 DECEASED (Type or print) DEATH Constable Frederick JE JINDER 24 HRS S SEX 9. AGE (In year 6 COLOR OR RACE 8 DATE OF BIRTH 7 MARRIED NEVER MARRIED lost birthdoy) Months တ် Dovs Hours WIDOWED DIVORCED Nov. 26. event White OIIO Oa USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT U. S. A. during most of working He, even if retired) INDUSTRY Railroad Storage Railroad Cumberland Maryland pages in any Exominer 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME pencil be executed within Allen J. W. Constable Minnie E. ond IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) or removol. Bessie Constable Bowmams Addition Unknown 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN AND DEATH OCCLUSION CORONARY IMMEDIATE CAUSE (o). This certificate should cremation, DUE TO buriol CORONARY SCLEROSIS Conditions if any, which gove rise to immediate couse (a). DUF TO stating the underlying couse bur,ol, c pelli PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPS PERFORMED? YES 🟋 NO F the certificate, designated agent, prior ta 200 EXTERNAL CAUSE WAS 20b DESCRISE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port I of Item 18) PRIMARY | or CONTRIBUTING | shimuld CAUSE OF DEATH 20e PLACE OF INJURY (Home, form, (City or town) 20c TIME OF IN. JRY Month, Doy, Year 20d INJURY OCCURRED (County) (Store) Hour o.m. Not While factory, street, office bldg., etc.) 19 pleose execute at work at wark Inspection 🙀 Inquiry for and in my apinian Suicide . Hamicide thm funerol director. death resulted from Natural causes 🔽 Accident Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE TO DEPUTY July 3, 1967 þe DEPUTY MEDICAL EXAMINER T Health or **EXAMINER'S** may Address (Street, city, town, or county) Gumberland, Md NAME (Type) BENEDICT SKTTARELIC M.D.

23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY 230 SUR.AL, CREMATION, 23d. LOCATION (City or Town) (Stote) 0 REMOVAL (Specify) Hillcreat Burisl Park Burial Cumber land

VR A15ME (5

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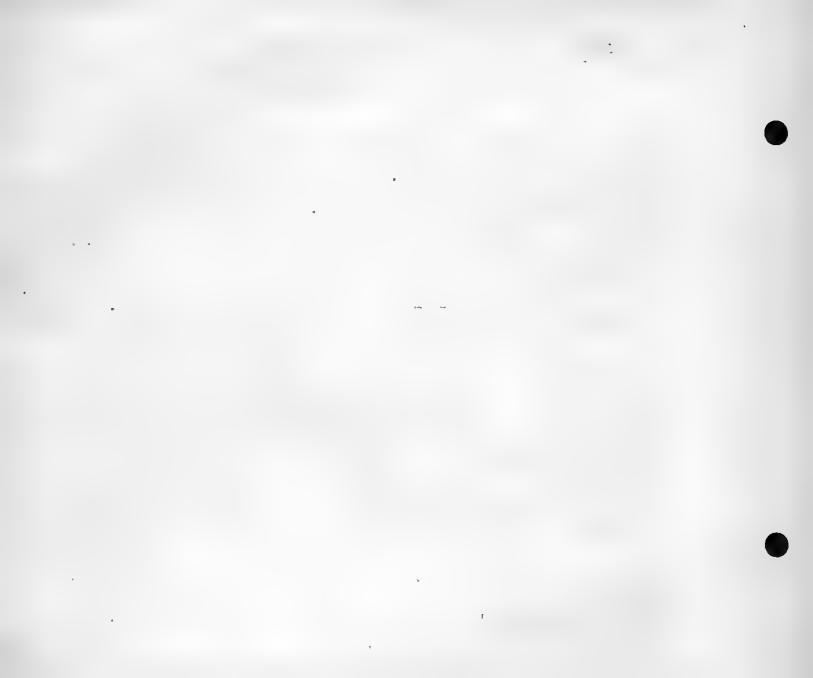
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. 1. PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN a. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION (if not in hospital, give street address) ON A FARM? ND X YES withIn Day 3. NAME OF DATE Year Middle OF DEATH DECEASED 19 (Type or print) executed AGE (In years IF UNDER 1 YEAR IFUNDER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED ast birthday! Months any DIVDRCED WIDDWED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even it retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT Ξ (County & State, or foreign country) physician en please r eval, and in þe INDUSTRY certificate removal, 13. FATHER'S NAME MOTHER'S MAIDEN NAME signed by the attending burial-transit permit. The burial, cremation, or remov 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. 17. INFORMANT (Yespige, or unknown) (If yes give war or dates of service) death CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) been signed DUE TO Conditions, if any, which gave rise to immediate the r DUE TO (a), stating the prior 1 underlying cause last. TO FUNERAL DIRECTOR: After this certificate has director, page 3 should be detached for use as should be filed with the State Dept. of Health prior (C) WAS AUTDPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING I OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a.m. While Not While at work ATTENDING p.m. retained 21. I certify that (I) (this hoppital) attended the deceased from 19. to. .M, from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. DIRECTOR PHYS. M.D. 4 may 22d. ADDRESS PHYSICIAN'S NAME (Type) or county) (State NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOI 23c. DEMOVAL (Speotry) un ADDRESS FUNERAL DIRECTOR VR A15 (4) Milconton 15M 4-64



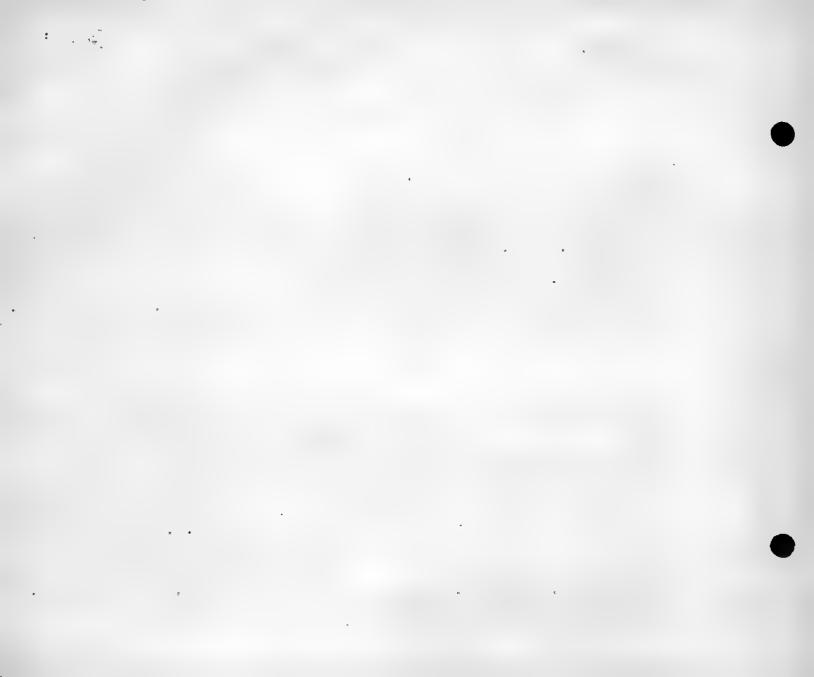
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3890E CERTIFICATE OF DEATH 02007 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY **b** COUNTY **ALLEGANY** ALLEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) 47 YEARS CUMBERLAND, MARYLAND, 21502 d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? SACRED HEART HOSPITAL 9 3 SETUAUDEDE AUG. YES NO IX Middle 3 NAME OF First 4. DATE Lost Month Day Year carbo DECEASED SYLVIA complete (LEANNA) CROSBY JULY 26 19 67 (Type or pnnt) and in ony event. DEATH S SEX 6 COLOR OR RACE AGE (In years HE UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH (Schorthdoy) Months FEMALE WHITE 3-1-02 WIDOWED DIVORCED puo 11 BIRTHPLACE (County & State or foreign country) 10o USUA, OCCUPATION (Give kind of work done 10b. KIND OF RUSINESS OR 12. CITIZEN OF WHAT Celanese Fibres COUNTRY U.S.A. MINERAL, KEYSER, W. VA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. HENRY KLAURA A. KIGHT HOSPITAL RECORD-SACRED HEART HOSP. 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 214-05-6132 No. buriol, cremotion. 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove nse to immediate couse (a). DUE TO storing the underlying cause Page 4 may be retained by the hospital or attending hos been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? NO K 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20f (City or town) (County) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (Stote) Hour ' a.m. factory, street, office bldg, etc.) Not While ot work ot work 21. I certify that (I) (this hospital) attended the deceased fram. , 19\_\_\_, that (I) (we) last M, fram causes and an the date stated above O FUNERAL DIRECTOR: \_\_\_\_19\_\_\_\_, and that death accurred at\_ saw the deceased alive an..... 22o SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS DIRECTOR PHYS 22d ADDRESS SMALLWOOD ST. CUMB., MD. director, pog should be file 22c PHYSICIAN'S CLARENCE J. VINCENT. M.D. NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23b DATE THEREOF 23d LOCATION (City or Town) (County) REMOYAL (Specify) 7/29/67 Bayard Cemetery Bayard, Grant. 2Sb REG STRAR S SIGNATURE 250, REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Mayles H. Wayne George Cumb. Md.

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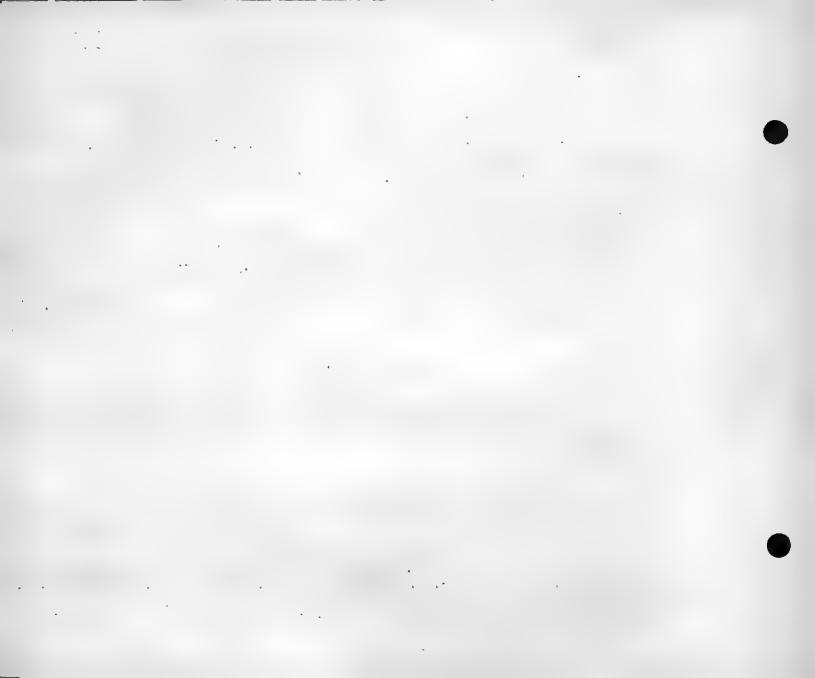
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 98989 requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY b. COUNTY ALLEGANY MARYLAND ALLEGANY MARYLAND c. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) Write RURAL and give regres E OWE AND CUMBERLAND 2WKS 25DAYS the attending physicion and completely filled in by sit permit. Then please remove corbor-pagers. P d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B. IS RESIDENCE ON A FARM? 809 ASHBROOK AVENUE MEMORIAL HOSPITAL NO T NAME OF 4 DATE First Midd e DOAK DECEASED RALPH BOWIE (Type or print) DEATH 8. DATE OF BIRTH 9 AGE (In years S SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** lost buthdoy) Hours 4-27-1913 WIDOWED DIVORCED MALE WHITE 10a USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT LEF CLERK **COUNTRY?** CUMBERLAND, MARYLAND USA 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME HENDERSON H. DOAK FRANCES LILLARD 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) [(If yes give wor or dates of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. YES 215 26 6914 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c)),
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN buriol-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse Page 4 may be retained by the hospital or attending os the prior to O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES NO 🗔 ٥ 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [ detached f te Dept. of I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or fown) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While of work 1967, to June 30, 1967 that (1) (we) lost 21. I certify that (1) (this haspital) ottended the deceased from 3 0 1967, and that death accurred at 4:47MAren/Couses and an the date stated above. saw the deceased alive on. 22g SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) THOMAS EWIS 500 GREENE ST. CUMBERLAND director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) 23o. BURIAL CREMATION. REMOVAL (Specify)
BURIAL SUNSET MEMORIAL PARK CUMBERLAND, MD. CUMBERLAND, ADDRESS 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE KIGHT VR A15 (4) 20 M 1/66



DIVISION OF STATISTICAL RESEARCH AND R	ECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	FICATE OF DEATH 08909
1. PLACE OF DEATH a. CDUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission. STATE D. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	IRYLAND ALLEGANY TAY IN 1D C. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town
CUMBERLAND, MD. 15 04	AYS LA VALE, MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street	II [ ON A FARM?
SACRED HEART HOSPITAL  3. NAME DF First Middle	P.O. BOX 12, 546 A ST. YES NOT
DECEASED (Type or print) ELIZABETH C.	DRESSMAN DEATH 7 12 19 67
5. SEX G. COLOR OR RACE 7. MARRIED X NEVER MARR	Months   Days   Hours   Min
FEMALE WHITE WIDOWED DIVORCE 10a, USUAL OCCUPATION (Give kind of workdone   10b. KIND OF BUSINESS	OR   11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN DF WHAT
during most of working life, even if retired) INDUSTRY HOUSEWIFE	ECKHART CO MARYLAND USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME EMMA XINAREX MARCZYNSKI
JOHN MILKOSKI  15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16, SOCIAL SECURITY	AMMAN MARCZINSKI
(Yes, no, or unknown) (If yes give war or dates of service) NO 215-20-6168	HUSPITAL SETUN DRIVE
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and	(c).1 INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  Coucline	files ONSET AND DEATH
Conditions, If any, which \ Custonia	1 -
gave rise to immediate	lugling.
underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU  20a. ACCIDENT WAS UNDERLYING []   20b. DESCRIBE HOW IN.  DR CONTRIBUTING [] CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	TNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   19. WAS AUTOPSY PERFORMED?   YES   ND   ND
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW IN. B DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)	JURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
2Dc. TIME OF INJURY Month, Day, Year   2Dd. INJURY DCCURRED   Hour a.m.   While   Not While   at work   at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. 1 certify that (I) (this hospital) attended the deceased	from
saw the deceased alive on19	, and that death occurred atM, from the causes and on the date stated abov
22a. SIGNATURE J. Vincens	M.D. PHYS. DIRECTOR PHYS.
1 22c. PHYSICHANS NAME (TYPE) DR. M. GLICK & DR. W. SEE	122d. ADDRESS 1GGLE 126 N. SMALLWOOD ST., CUMBERLAND MD.
REMOVAL (Specify) of / 11/ / 7 / //	CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY-REGISTRAR 25b. REGISTRAR'S SIGNATURE
James Stein Jac (unt	127 DATE JUL 17 1951 July 1951



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 0201 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. COUNTY o STATE **b** COUNTY ALLEGANY ALLEGANY MARYLAND b CITY OR TOWN (If outside carparate limits, C LENGTH OF STAY IN 16 requires that the death certificate be executed within 24 hours aft c CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) write RURAL and give paggest town AND yd ni 5 DAYS LA VALE d, NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? SACRED HEART HOSPITAL by the ottending physician ond/completely filler ransit permit. Then please remove atribon pop tremation, or removal, and in ony event, within NO TX YES 3 NAME OF Middle 4. DATE Month Day Year (Type or print) GEORGE DRESSMAN 18-67 Α. 19 DEATH IF UNDER 1 YEAR S SEX IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years last birthdoy) Months Days MALE WHITE WIDOWED DIVORCED 7-13-96 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT COUNTRY? CUMBERLAND, MD. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME DETERMAN MARY JOSEPH 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates of service HOSPITAL RECORD, 200 SETON DRIVE, CUMB., MI 218-30-0709 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit burial, cremati ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the prior to b has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) epsesour. NO X this certificate 200 ACCIDENT WAS JAPERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II af item 18): OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or fown) (County) (Stote) Haur a.m. Nat While factory, street, affice bldg., etc.) at work at wark TO FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram and that death accurred at 1:20 P.M. Gram sauses and an the date stated above. saw the deceased alive an 22a, SIGNATURE 22b DATE SIGNED M.D. DIRECTOR 22d. ADDRESS 22c PHYS.CIAN'S ncent rence director, po should be f NAME (Type) 23d LOCATION (City or Town) COMPTERY OR CREMATORY (State) 23a BUR AL CREMATION (County) -REMOVAL (Specify) 250 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR STREET VR A15 (4) 20 M 1/66 STEINS FUNERAL

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) n COUNTY 2, and 3 ta PM3. Page g STATE b COUNTY Alleganu Maruland Allegany MARYLAND b CITY OR TOWN (foutside corporate limits, writ "Lavale 7" wn) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) Lavale. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS 8 S RESIDENCE 19 Glenview Terrace 19 Glenview Terrace in Item 18. Give Pages YES NO IX Office along with NAME OF Middle Last 4 DATE Month DECEASED OF DEATH Julian Cline. Driver July 19 67 IF UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED 8 DATE OF BRTH 9 AGE (In years IF UNDER 24 HRS NEVER MARRIED last\_buthday) Months White Oct. 22, 1902 WIDOWED X DIVORCED any event within 72 haurs after death 11 BIRTHPLACE (State or foreign country) 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT Transit Co. New Market. Va. e, writing the ward "pending" in penal in farwarded to the Chief Medical Examner's 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Dorilas J. Driver Barbara Rosenberger 16 SOCIAL SECURITY NO 17 INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war ar dates af service) 241-10-5553 Mr. J. Wayne Driver Fairfax. Va. TB CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN CORONARY OCCLUSION IMMEDIATE CAUSE (a) \_ DUE TO CORONARY SCLEROSIS Canditions, if ony, which gave rise to immediate couse (a), DUE TO stating the underlying cause PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter nature of injury in Part or Part It of item 18.) PRIMARY CONTRIBUTING CAUSE OF DEATH 20f (City or town) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Hame, farm, (County) Haur o.m While at work of work factory, street, affice bldg, etc.) Inquiry X. 21. I certify that I taak charge of the remains described above, held on Autapsy [X]. Inspect on [X], and in my apinian Natural causes X, Accident , Suicide , Hamicide death resulted fram: Undetermined manner 7/26/67 CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER M.D. DEPUTY MEDICAL EXAMINER Cumberland, Md. Benedict Skitarelic, M. D. Address (Street, city fawn, ar county) 230 NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (City or Town) 230 BUR AT CREMATION Burial Burial 7/29/67 Sunset Memorial Park Cumberland, Allegany, Md. 24 FUNERAL DIRECTOR VR A15ME (5) H. Wayne George Cumb. Md. 6M 1/67

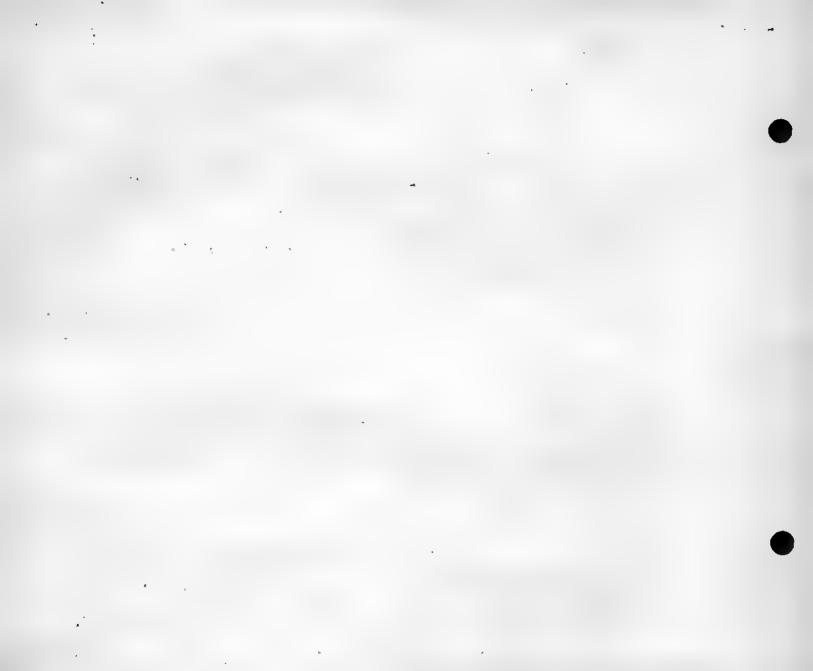


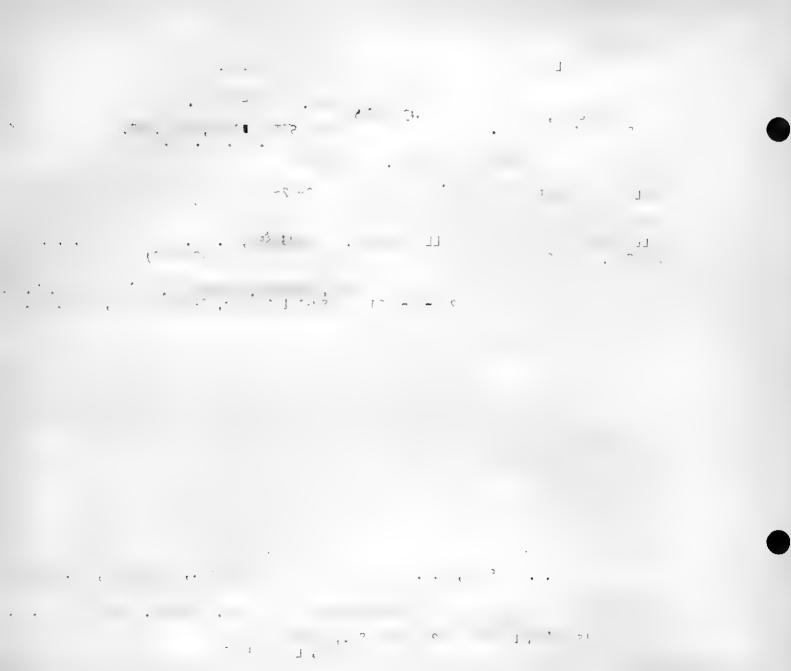
- 1 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	18913 Item 10a, Film 1990 7/21707 Cac 08912
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afte ges afte	b CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
by the further by the	write RURAL and give neorest town)  CUMBERIAND 3WKS.1DAY FROSTBURG
filled in the throng the through the throng the throng the throng the throng the throng through the throng throng through the throug	CLIMBERIAND 3WKS 1DAY  d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d STREET ADDRESS  e IS RESIDENCE ON A FARM?
= 1	MEMORIAL HOSPITAL 144 WOOD STREET YES NO N
<i>!</i>	3 NAME OF First Middle Lost 4 DATE Month Day Year
Ì	OF DECEASED (Type or print) ROBERT D. EWING DEATH JULY 8. 1967
	S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years I FUNDER 1 YEAR 1 FUNDER 24 HE
	WIDOWED DIVORCED 11-14-1897 69 vis
	100 USUAL OCCUPATION (Give kind of work done done done during most of working black your foreign country)  12 CIT ZEN OF WHAT COUNTRY?
	REVVIKED ENGINEER BUREAU OF MINES   MARYLAND   USA
	13. FATHER'S NAME
	JOHN EWING DELLA JONES
	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address  (Yes, no Worknown) (If yes give wor or dotes of service) 218-24-8364 MFMORIAL HOSPITAL CUMBERLAND MD
	MEMORIALHUSPITAL, COMBERLAND, MU.
	18. CAUSE OF DEATH (Enter only one couse per line to (a), (b), and (c).) PART I, DEATH WAS CAUSED BY.  INTERVAL BETWEEN ONSET AND DEATH
	IMMEDIATE CAUSE (o)
	Conditions, if ony, which gove ) DUE TO CONTROLLS CAPAL ON CONTROLLS 310/12
	nse to immediate cause (o),
	toting the underlying couse (c)
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY
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	205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
ı	20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20 (County), (County)
	pm. of work of work of the state of the stat
	21. I certify that (I) (this haspital) attempted the deceased fram bills of 19 to 7/8/67, 19 that (I) (we)
	saw the deceased alive an 7/5/1/2 19 , and that death accurred all 1 22 3/12 from causes and an the date stated about
	M.D. ATTENDING MED. STAFF 22b. DATE SIGNED.
3	PHYSICIANS  NAME (Type) DR. R. J. WILLIAMS  22d. ADDRESS  CUMBERLAND, MARYLAND
1	230 BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote)
	BURTAL (Specify)  JULY 12 '67 FBG. MEMORIAL PARK  FROSTBURG, MD.
	24. FUNERAL DIRECTOR ADDRESS 250. RECIO BY REGISTRAR 195 756. REGISTRAR'S SIGNATURE
of a	JOSEPH R. DURST, SR., FROSTBURG, MD.



- - - + 17/1/ 2 ° 115

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12011 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) signed by the attending physic an and campletely filled in by the funeral burial-transit permit. Then please remave ferboa papers. Pages I and b. COUNTY llegany o. STATE aryland o. COUNTY Allegany MARYLAND b (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 Midland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM Miners Hospital YES 🗔 NO. Middle NAME OF 4. DATE Month Doy Year LOST DECEASED OF GOODRICH ANNA 19 Type or print) DEATH IF UNDER 24 HRS S SEX 6. COLOR OR RACE B DATE OF BIRTH AGE 7. MARRIED NEVER MARRIED birthdoy) Months Female White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) TOB. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY Mt. Savage, Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, or removal, Helena Hahn Herman Steele 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) Herman Kamauff None Lonaconing, Md. INTERVAL BETWEEN SON 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART 1 DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the shauld be filed with the State Dept. of Health priar to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NONE NO F 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 200 ACC DENT WAS UNDERLYING . OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) of work ot work deceased fram 5/20, 1967, to 7/3, 1967, that (1) (we) last 1962, and that death accurred at 5500 M, fram causes and an the date stated above. 21. 1 certify that (1) (this haspital) attended the deceased fram. saw the deceased alive an. 22b DATE SIGNED 22o. SIGNATURE ATTENDING MED DIRECTOR STAFF PHYS PHYS 22d. ADDRESS Prostburg, Md. 22c. PHYSICIAN'S NAME (Type) Martin Rothstein 230 BURIAL, CREMATION, REMOVAL (Specify) 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF (County) (Stote) /16/1967 German Lutheran Frostburg. Md 24. FUNERAL DIRECTOR 250. REC D BY REGISTRAR 250 REG STRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Lonaconing, Md. George Eichhorn .



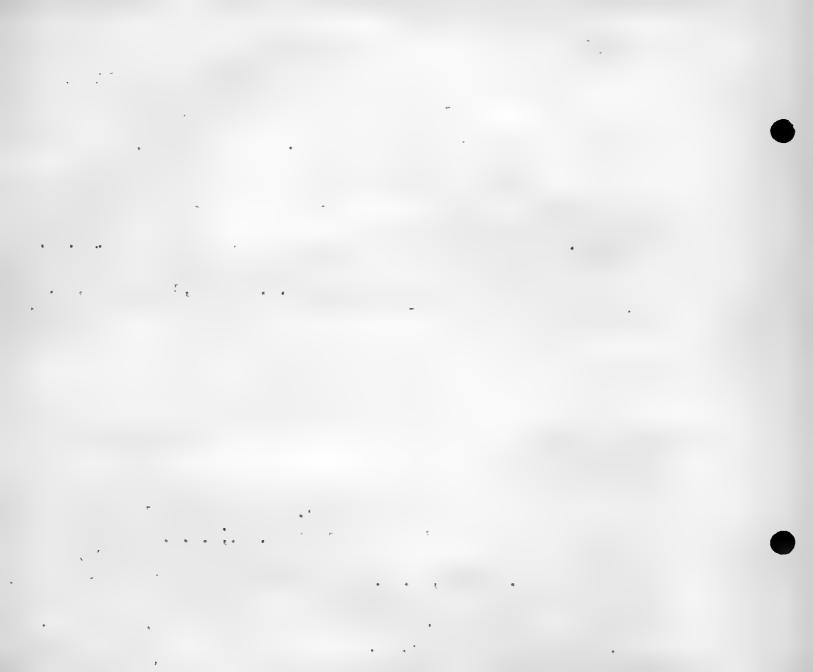


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY Allegany b. CITY OR TOWN (if outside corporete limits, write RURAL and give nearest town) Marvland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 Cumber Land Comberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? hours Memorial Hospital 410 Louisiana Avenue NO X NAME OF Middle 4 DATE Month DECEASED (Type or print) DEATH Margaret Heberle 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | last birthdey) | Months | Days | Hours | Min. 7. MARRIED X NEVER MARRIED 9/18/1900 White WIDOWED DIVORCED [ l and event 103. USUAL DCGUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA Housewife Illinois 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Emil Rokos Maria 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SQCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknwn) (If yes give war or dates of service) EXAMINER: This certificate should be executed within the certificate, writing the word "pending" in pencil is should be forwarded to the Chief Medical Examiner's 341-07-1855 Carl Heberle, 410 Louisiana Ave., Cumberland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ] INTERVAL BETWEEN PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e). ONSET AND DEATH burial-transit Myocardial Infarction DUE TO Conditions, If any, which Occlusion 2 Hours Coronary gave rise to immediate DUE TO cause (a), stating the Sclerosis œ Coronary used as a to burial, underlying couse lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION WAS AUTOPSY PERFORMED? YES T NO X 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 3 should t MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ) 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While at work at work Inquiry and In my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection death resulted from: Natural causes ICX. Accident Suicide Homicide Undetermined manner YOUL CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER X July 18, 1967 **EXAMINER'S** director. retained Address (Street, city, town, or couffumberland. Md. Benedict Skitarelic, M.D. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 0 Burial Adalberts Cemetery Niles. REC'D BY REGISTRAR 254. 24. FUNERAL DIRECTOR ADDRESS VR ALSME (5) Cumberland MA



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 08918 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) PLACE OF DEATH b COUNTY Allegany o. COUNTY Maryland Allegany MARYLAND requires that the deoth certificate be executed within 24 hours after b CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURA, and give nearest tawn) 12/23/1961 Cresaptown Cumberland d NAME OF MOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM d. STREET ADDRESS Rt. # 5 Winchester Rd. Allegany County Infirmary NO TO 3. NAME OF DECEASED (Type or print) Middle 4. DATE First Dav Year OF DEATH John Helbig July 67 Frank 19 B. DATE OF BIRTH AGE (In years 1F LINDER 24 HIRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Marths Davs Hours Male White 9/19/1884 WIDOWED DIVORCED 10a usual occupation (Give kind of work dane during most of working life, even if retired)

Retired Railroad Worker (Switchman) 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT Cumberland, Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME John Helbig Bridget Henaghan 17 INFORMANT P.O. Box 599, Cumberland, Md. 21502 16. SOCIAL SECURITY NO WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give war or dates at service) Allegany County Infirmary records. 705-07-9552 INTERVAL BETWEEN IB CAUSE OF DEATH (Enter only one couse per fine for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a) DUE TO stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONFRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. Nat While factory, street, office bldg., etc.) 23, 19 67, ta July 7, 19 67, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram\_ director, page 3 should should be filed with the 10:15 ATTENDING 22a. SIGNAJURE MED.
DIRECTOR STAFF PHYS. 7/17/1967 M D 22d ADDRESS Memorial Hospital, Cumberland, Md. 22c PHYSICIAN'S A. Topper, M. D. MAME (Type) John 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF 230 BURIAL, CREMATION, (State) REMOVAL (Specify) 7/20/67 SS. Peter & Paul Cemetery Cumberland Allegany, Md.
ADDRESS 250. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) H. Wayne George Cumberland, Md. DATEJUL 2 4 1967



1	Division of STATISTICAL RESEARCH AND RECORDS	5, 301 W. PRESTON STREET, BALTIMORE, M/	ARYLAND 21201
	08919 CERTIFIC	CATE OF DEATH	08918
the feeth.	1. PLACE OF DEATH  a COUNTY  ALLEGANY  MARYLAI	MARYLAND MARYLAND	ALLEGANY
within 24 hours after by filled in by the opposes. Pages I within 72 hours offer	b CITY OR TOWN (1 outside corporate limits, write RURAL and give negrest town)  CUMBERLAND  7HRS. 10A	MINICUMBERLAND	te RURAL and give nearest town)
in 24 h	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  MEMORIAL HOSPITAL	d. STREET ADDRESS 727 SYLVAN AVE.	ON A FARM? YES NO X
ed with	3 NAME OF PECEASED (Type or phnt) HUNTER B.	HELFRICH OF DEATH	JULY 1 1967  ors   IFUNDER   YEAR   IF JNDER 24 HRS.
execute and comp	S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	3 - 17 - 1886  9. AGE (In yet loss) 8 Three loss 8 Three	ay) Manths Doys Hours Min
certificate be executed within 24 g physician and completely filled Then please remove carban pape maval, and in any event, within 7.	100 USUA. OCCUPATION (Give kind of work done during most of working He, even if retired)  Retired General Contractor  13 FATHER'S NAME	Allegany Co Maryland	COUNTRY? USA
certific ng phys Then p maval,	JOHN HELFRICH  IS WAS DECEASED EVER IN U.S. ARMED FORCES?  I 6. SOCIAL SECURITY NO	LAURA JUDY	Address
e death ce attending   permit. The	(Yes, no, or unknown) (If yes give wor or dates of service) 2111-05-7230	MEMORIAL HOSPITAL, CUM	MBERLAND, MD.
equires that the physician. signed by the burial-transit burial, cremati	18. CAUSE OF DEATH (Enter only one couse per line fob (o), (b), fine (c)) PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (d)  DUE TO  Conditions if ony, which gove tise to immediate couse (o), stoting the underlying couse lost.  (c)	is CID for	NIERVAL BETWEEN ONSET AND DEATH
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PHYSICIAN: e hospital ar his certificate stached far u Dept. of Heal	OR CONTRIBUTING CICAUSE OF DEATH  (IF FITHER NOTIFY MEDICAL PRAMINERY)	JRRED (Enter nature of injury in Port I or Port II of Item 1	8.)
NG PHY y the ho er this o e detach ate Dep	Hour o.m. 19 While Net While of work , of work	De PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	4 aller Mit
TO HOSPITAL OR ATTENDING PH Page 4 may be retained by the h TO FUNERAL DIRECTOR: After this director, page 3 should be detail shauld be filed with the State Dep	2). I certify that (I) (this hospital) attended the deceased fresum the deceased alive on	om/// 6- 19 , to de that death accurred att. 15 My fram con	uses and on the dote stated obove
D HOSPITAL OR ATTENI Page 4 may be retained D FUNERAL DIRECTOR: A director, page 3 should should be filed with the	1. MMARKEURIT	M.D. ATTENDING MED STAFF PHYS DIRECTOR PHYS 22d. ADDRESS	0 7/2/6/
ro Hospital Page 4 may To FuneRal ( director, page shauld be file	ZZC. PHYSICHAN'S NAME (Type) RICHARD J. WILLIAMS M. J. 230. BURIAL CREMATION.   23b. DATE THEREOF   23c. NAME OF CEMETE		
TO HO Page TO Full directshare	DESCRIPTION OF THE PROPERTY OF	&Paul Cemetery Cumberla	nd Allegany Maryland
VR A15 (4)	H. I.e. Silcox Cumberland Marriand 21	HH # 4007	Milarles Judges

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY Allegany Maryland Allegany MARYLAND b (ITY OR TOWN (If outside corporate imits write RURAL and give nearest town)
Cumberland C LENGTH OF STAY IN 16 c CTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 years Cumberland e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS Rt. 40-4 Miles East Cumberland, Md. 1008 Oldtown Road YES NO EX 3 NAME OF 4 DATE Doy Year DECEASED July (Type or print) 19 DEATH Dennis Helmick Roger IF UNDER 1 YEAR NEVER MARR ED B DATE OF BIRTH 9 AGE (In years 6 COLOR OR RACE 7 MARR ED lost birthdov) Days Hours June 8, 1946 Male White W DOWED D VORCED 11 BIRTHPLACE (State or foreign country) 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Railroad Cumberland, Md. USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Twyla Broll Foster S. Helmick 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service Foster S. Helmick, Cumberland, Md. Father no NTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c) PART I DEATH WAS CAUSED BY. Minutes Hemothorax, bilateral IMMED ATE CAUSE (o) Crushed Skull Sudden DUF TO Conditions, if any, which gove Severed Spine Sudden rise to immediate cause (a), DUF TO stoting the underlying couse 9 WAS AUTOPSY PERFORMED? YES (K) NO PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter notuse of in any in Port 1 or Port II of item 1B) CAUSE OF DEATH Passenger on single motorcycle accident
NURY OCCURRED 200 PLACE OF INLURY (Home, form, 20f (City or town) (Stote) 20c TIME OF N. RY Month, Day Year while of work of work Rt. #40, if miles East, Cumberland, Alleg. Md. 21 1 certify that I taak charge of the remains described above, held an Autapsy [X], Inspection [X], Inquiry [X], and in my aprilar death resulted from Natural causes Accident XX Suicide Hamic'de Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER

form in Item 18. Give Pages certificate should be executed within 24 hours ofter death Office olong with event with n 72 haurs after death e, writing the word "pending" in pencl in forworded to the Chief Medical Examiner's ony ( and cremotion, or removal, 3 should FUNERAL DIRECTOR: Poge the funeral d rector 500

FOR STATE HEALTH DEPT.

> BENEDICT SKITARELIC. M.D. NAME (Type) 23b DATE THEREOF Burial July 25,1967

DEPUTY MEDICAL EXAMINER X July 22, 1967 Address (Street, city, town, or county Cumberland, Md.

23d LOCATION (City or Town)

230 BURIA, CREMATION

James F. Scarpelli, Cumberland, Md.

23c NAME OF CEMETERY OR CREMATORY

Davis Memorial Cemetery Cumberland, Md. Allegany

ADDRESS

250 RECORD REGISTRAR 255 REJISTRAR S GAMIURE

Parland, Md.

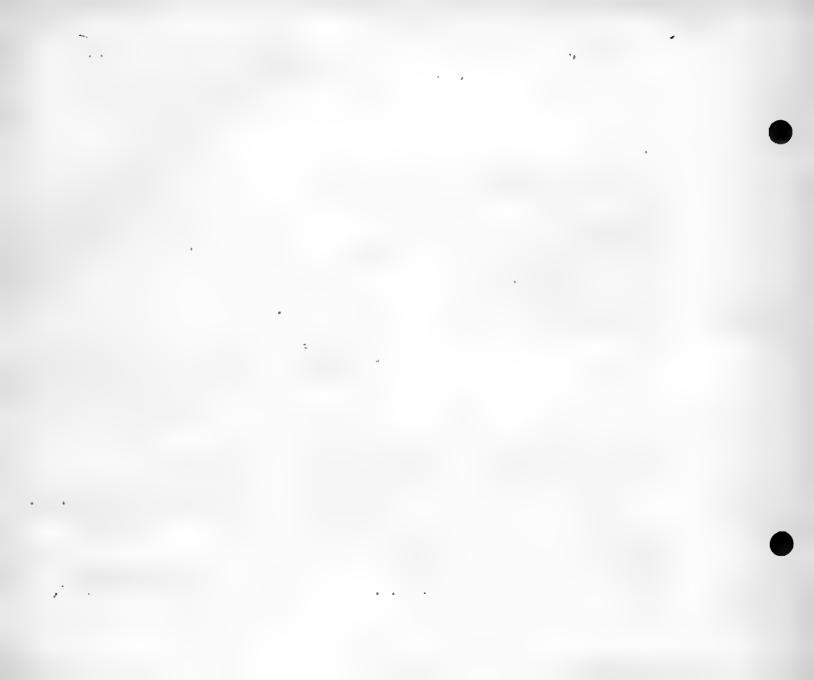
DATE

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(County)

VR A15ME (5) 6M 1/67

24 FUNERA, DIRECTOR





1	MARYLAND STATE DEPARTMENT OF HEALTH
TOP OTLE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  OCODO MEDICAL EXAMINER'S CERTIFICATE OF DEATH  28921
FUK STATE	- 0344
SE -	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, if institution: Residence before edmission) 3. COUNTY 4. COUNTAIL RESIDENCE (Where decessed lived, if institution: Residence before edmission) 5. COUNTAIL RESIDENCE (Where decessed lived, if institution: Residence before edmission) 6. STAMaryland 6. COUNTAIL RESIDENCE (Where decessed lived, if institution: Residence before edmission)
ctor. Page of Haabb	b. CITY OR TOWN (if outside comporate fum'ts. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside comporate fum'ts, write RURAL and give neerest lown)
s mace rector your d of t	write RURAL and give neerest town) (Rural) Frostburg
s = e direct or you	d. NAME OF HOSPITAL OR INSTITUTION From a hospital, give streat address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARMY
ed fe	HIGHWAY # 36
o the funera the funera the State B ter death.	3 NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF COLOR
# to the #	(Type of print)  RICHARD  A. HUNT  DEATH 7/2/1967  19  SEX  16. COLOR OR RACE 7. MARBIED   NEVER MARBIED   18. DATE OF BIRTH  19. AGE (In years   IF UNDER 1 YEAR IF UNDER 24 HRS.)
er death if and 3 to fi 5 may be r 1 2 with th nours-effer	SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   B. DATE OF BIRTH   9. AGE (In years   IF UNDER 1 YEAR   F UNDER 24 HRS.   last highber)   White   WIDOWED   DIVORCED   3/9/1950   9. AGE (In years   IF UNDER 1 YEAR   F UNDER 24 HRS.   Hours   Min.   Winder 24 HRS.   Hours   Min.   Hours
tter 2, ar 5 rr 1d 2 hou	10a. USLAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDI-STRY L.11. RIRTHPLACE (Stein or foreign country)
urs a lar lar 172	Student (Beall High School) Frostburg, Md. USA
Page 43. Fages ages	13. FATHER'S NAME
n 24 sive P n PM le pa nt wi	Richard W. Hunt Thelma Ringer
Arthin 18. Gi	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC.AL SECURITY NO. 17. INFORMANT (Yes, no. or unkown) ((flyosgivawerordelesofservice) NO  Richard W. Hunt (Rural) Frostburg, Md
se executed vicil in Item I along with Irransit perm	NO Richard W. Hunt (Rural) Frostburg, Md
e execution in the salong transit in and in	PART I. DEATH WAS CAUSED BY:
bee encil e ald l-tran	** DUE TO STOCK; EXAUGUACION
" in pen Office burial-t	Conditions, if any, which \( \) (b) Severed left leg; compression of chest "
(U ∩ N /0 @)	geve rise to immediate cause  [a], stating the underlying DUE TO
ertificate 1 "pendin Examiner s used as	Causa last, (c)
	PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO -  20a. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING    CAUSE OF DEATH.
: This of wor sedical could be cremit	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of Item 18.)
民事を指揮し	
MINE vriting Chief / 3 sge 3 s	S 20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20c. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stale)
KC P B Co.	Rt #36 -2Mi.north, Midland, Alleg. Md.
L EX ficate, to the	21. I certify that I took charge of the remains described above, held an Autopsy 📉 Inspection 📉. Inquiry 🛣, and in my opinion
ICAI certifi rided recri	death resulted from. Natural causes . Accident . Suicide . Homicide . Undetermined manner .
H H W H H	ACTUAL ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED
Y N cute to to AL anate	SIGNATURE DEPUTY MEDICAL EXAMINER TO 10.1 - 2 1067
DEPUTY MCCICA.  asse execute the certification of t	NAME (Type) BENEDICT SKITARELIC M.D. Address (Street, city, town, or county) Cumberland, Md.
Should its	22a, BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (State)
5 g 4 5 g	Burial 7/5/1967 Memorial Park Frostburg, Md.  23. Funeral Director Address 246. Registrar: Signature
VS. AISME	[644
SM 9/60	GEORGE EICHHORN Lonaconing, Md. JUL 5 1967 Charles Judge



1	MARYLAND: STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	08923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08922
leath. If any detay is necessary, and to the funeral director. Page as be retained for your files. With the State Board of Health, is after deeth.	1. PLACE OF DEATH  a. COUNTY  Allegany  MARYLAND  b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)  write RURAL and give nearest fown)
	Frostburg  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Miners Hospital  Street Address  d. STREET ADDRESS  d. STREET ADDRESS  NO   VEST NO   TO THE TRUE
	3. NAME OF DECEASED (Type or print)  GEORGE R. HUSK  S. SEX  G. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH  Day Year OF DEATH July 8th. 1967 19  9. AGE (In years   IF JNDER 1 YEAR   IF UNDER 24 HRS   Is thirthday) Months Days Hours Min.
hours the	Male   White   W.DOWED   DIVORCED   Jan, 14th. 1914   53 yrs.    10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if rel red)  Farmer   10b. KIND OF BUSINESS OR INDUSTRY   11. BIRTHPLACE (State or to MISSOURI Aniston, MISSOURI USA)  13. FATHER'S NAME   14. MOTHER'S MAIDEN NAME
within 24 18. Give P h form PM mit. File pa y event wi	James Husk  Susan Parker  15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unkown) ((Hyzergive warrordeteasofservice)  Mrs. Easter Husk East Prarie, Missour
cate should be executed anding," in pentil in liem niner's Office along withdays as a burial-transit per or removal, and in an	BB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PARY I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  Coronary Occlusion  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (c)  Wife)  (Wife)  (Wife)  (Wife)
IEE: This certifing the word "pring the word "pring the word "pring the world be use it is a companion to the world be use it is a companion to the world th	PART II. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMEDY YES NO 12  20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE OF DEATH.
SAL EXAMIN stiffcate, writing ed to the Chie CTOR: Page 3	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.  19   20d. NJJRY OCCURRED   20e. PLACE OF INJURY (Home, farm, p.m. at work   20f. (City or town)   (County)
VUIN NEEDIC execute the ce id be forward IERAL DIRE	ACTUAL SIGNATURE SIGNATURE  DEPUTY MEDICAL EXAMINER D  DATE SIGNED  DEPUTY MEDICAL EXAMINER D  DEPUTY MEDICAL EXAMINER D
please exe please exe A should to ro runer or its design	NAME (Type)  Benedict Skitarelic Cumbersland, crematory  226. Burial, CREMATON, 22b. Date THEREOF  22c. NAME OF CEMETERY OF CREMATORY  REMOVAL (Specify)  7/11/1967 East Pearie.  Missouri.
YS. AISME SM 9/60	George Eichhorn, Lonaconing, Md.  ADDRESS  24a. REC'D BY REGISTRAN'S SIGNATURE DATE  DATE

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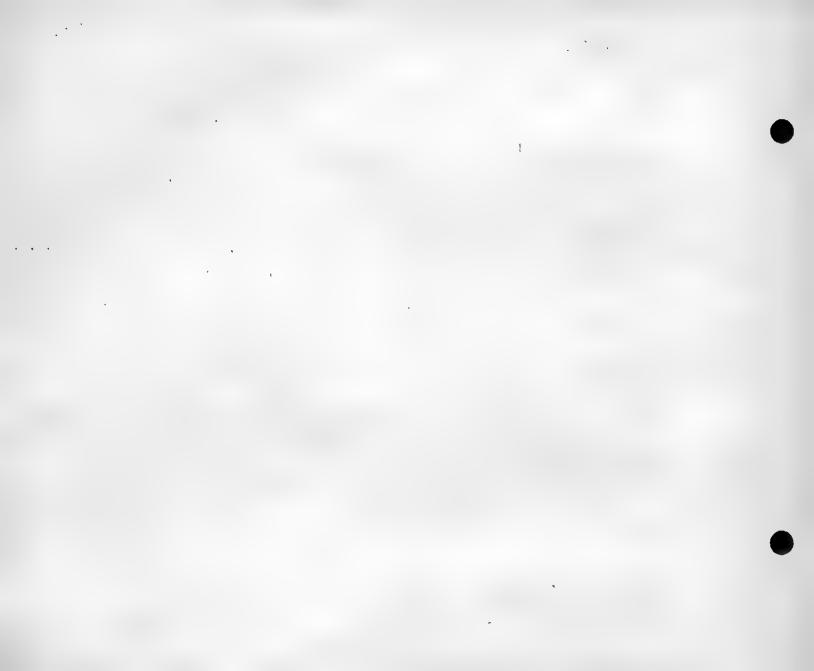
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. CERTIFICATE OF DEATH 08924 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) completely filled in by the funeral laye carbon papers. Pages I and PLACE OF DEATH n COLINTY n. STATE b. COUNTY **ALLEGANY** ALLEGANY MARYLAND MARYLAND b CITY OR TOWN (If outside corporate l'mits, write RURAL and give nearest town)

CUMBERLAND c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) IO DAYS FROSTBURG, MD. 21532 d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? ROUTE #2 SACRED HEART HOSPITAL YES X NO event with 3 NAME OF Middle 4. DATE First LOST Month Doy Yeor DECEASED 67 ROBERT PATTERSON JAY 19 (Type or print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF JNDER 24 HRS 7. MARRIED **NEVER MARRIED** remaye lost birthdoy) Dovs Haurs MALE WIDOWED DIVORCED 8/11/90 WHITE the attending physician and sit permit. Then please rem 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 11, 8IRTHPLACE (County & State, or fareign country) during most of warking life, even if retired) INDUSTRY COUNTRY? FARMER U.S.A. FARMING ARTEMAS .\_PA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME AGNES (BARKMAN) SAMUEL 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes af service) 17. INFORMANT 16 SOCIAL SECURITY NO. Address HOSPITAL RECORD 196-22-0061 SACRED HEART HOSPITA INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), I-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by burial-trans DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) use YES 🗍 NO TV ā 20o, ACCIDENT WAS UNDERLYING [ 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury to Part 1 or Port 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg, etc.) Haur a.m. Nat While of work at work Page 4 may be retained by . 1962, that (1) (we) last 21. I certify that (!) (this haspital) attended the deceased from 7-10 , 1962, to 7-20 shauld 19 6 7, and that death accurred at M. from causes and on the date stated above. sow the deceased alive on. 22b. DATE SIGNED 22o, SIGNATURE **ATTENDING** -22-6 M.D DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S W. C. SPIGGLE. NAME (Type) M. 126 N. SMALLWOOD, CUMBERLAND, MD director, shauld 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) BURY AL (Specify) JULY 23. 1967 FAIRVIEW CHRIST, CHURCH PENNA 19626. REGISTRAR'S SIGNATURE 250. REC PIRY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) JOSEPH R. DURST, SR., FROSTBURG, MD. 21532 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY ALLEGANY MARYLAND ALLEGANY campletely filled in by the acre carbanesecope. Pages c. LENGTH OF STAY IN 1h c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits WINE RURAL and give neglet NOWE RLAND CUMBERLAND DAYS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS within 72 MEMORIAL HOSPITAL FREDERICK STREET YES NO K 3. NAME OF First DATE Manth Last Day Year DECEASED WILLIAM JOHNSON JULY DEATH 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** signed by the attending physician and camp burial-transit permit. Then please remave last birthdoy) Months Days Hours 2-18-187 MALE WHITE WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, at foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** SOMERSET. PA. USA AIRY AND INSURANCE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal. REUBON JOHNSON MARY PINKERTON 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknown) (If yes give war ar dates of service) 01 MEMORIAL HOSPITAL COMBER CAUSE OF DEATH (Enter only one cause partine for (o), (b), and (c).) burial-transit PART! DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) physician. DUE TO Conditions if any, which gove rise to immediate cause (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Health NO F 200 ACCIDENT WAS UNDERLYING [2] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Slate) 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg , etc.) Hour a m Not While at wark at work 21. I certify that (I) (this haspital) attended the deceased fram 3 shauld and mar death accurred at 4:35M. Aram causes and on the date stated above saw the deceased alive an 22o. SIGNATURE 22b DATE SIGNED DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS NAME (Type) 122 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g. BURIAL CREMATION REMOVAL (Specify)
BURIAL JULY 25,1967 ST. LUKES CEMETERY CHMBERLAND REGD BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) BYRON KIGHT CUMBERLAND. MD. 20 M 1/66 DATE





Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 24201 CERTIFICATE OF DEATH 0892 in by the funeral ers. Pages 1 and 2 death requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. STATE o. COUNTY b. COUNTY Allegany Marvland Allegany MARYLAND b. (ITY OR TOWN (if outside corporate limits, write RURAL and give negrest town)

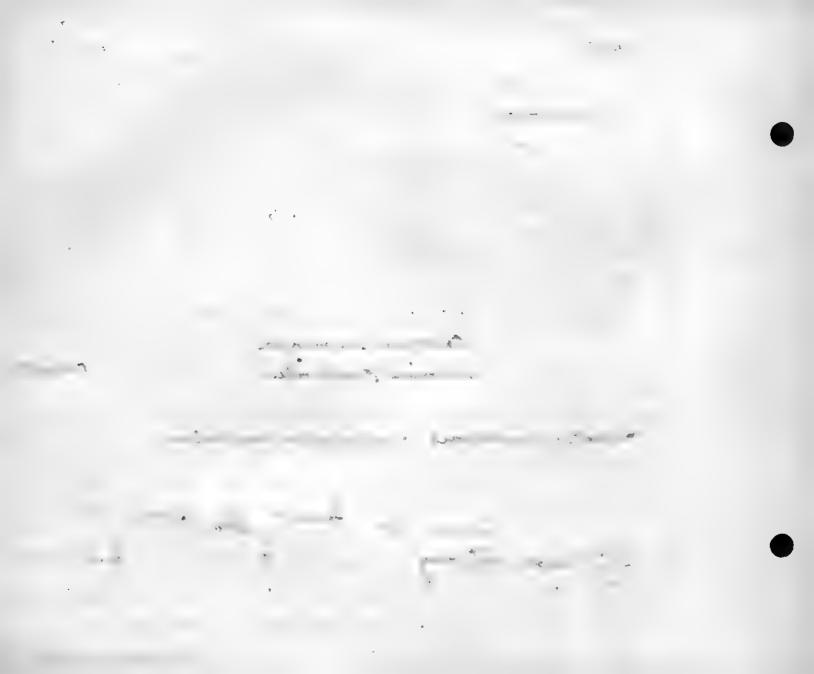
Cumberland c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 3 Years IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS oletely filled i carban paper 210 Harrison Street 11 210 Harrison Street □ N0 fc= 3 NAME OF Middle Lost 4. DATE Year Month Day DECEASED July Charles Ε. DEATH 67 Type or print) Jones signed by the attending physician and camplest burial-transit permit. Then please remave carl burial, crematian, or remaval, and in any events 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** physician and camp 10st birthdoy) Months Doys Hours WIDOWED DIVORCED Dec 7, 1907 Male White 12. CITIZEN OF WHAT IDo \_SUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) during most of working life, even if retired)
Textile Worker— Celanese COUNTRY? **NDUSTRY** Corp of America Meyersdale, Penna 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Minnie Smith Jones - NOW MAKE Harry IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Addre 10 Harrison St (Yes no, or unknown) (If yes give wor or dotes of service) Mrs. Cecile Jones Cumberland, Md No INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUF TO levio sclevolie Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar to has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO TO FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) 2Dc TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work of work 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 1966. to 390h be retained director, page 3 should should be filed with the 29 June 1967, and that death accurred at 24. M, fram causes and an the date stated above saw the deceased alive-an 22b. DATE SIGNED 22o. SIGNATURE MED DIRECTOR ATTENDING M.D. PHYS. 22d ADDRESS 22c PHYSICIAN'S Smallwood et lumber NAME (Type) 23o. BUR-AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) 7/6/67 \*\*\* St. Lukes Cemeterv Cumberland Allegany Maryland 25b. REGISTRARS SIGNATURE **ADDRESS** 25o. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 H. Lee Silcox Cumberland, Maryland 21502



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item 18. Film Gyyl 5, 15 USUAL RESIDENCE (Where deceased I vad, I astitution: Residence before ed r sson) . PLACE OF DEATH COUNTY Allegany MARYLAND b. CITY OR TOWN (if outs do corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown write RURAL and give neerast lown) Cumberland Minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d STREET ADDRESS a. IS RESIDENCE ON A FARM? Sacred Heart Hospital YES NO 3. NAME OF Erst DECEASED OF (Type or print) 7 MARRIED THEYER MARRIED THE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR), IF UNDER 24 HRS. last birthday) Months Devs 10a. USUAL OCCUPATION (GIVE Kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 B RTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Cover, MA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Cora alice Sicione Lewis Kamp 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17, INFORMANT (Yas, no, or unkown) | (Ifyesgivewarordatasofsarvice) Persie Kamp, Grantsville, L. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), end (c), INTERVAL BETWEEN ONSET, AND DEATH PART I. DEATH WAS CAUSED BY: Gorenary Occlusion JULIEII IMMEDIATE CAUSE (e) DUE TO Coronary Scleros's Conditions, if any, which' geve rise lo immadiate cause DUE TO (e), stelling the underlying cause lest. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a), 19, WAS AUTOPSY PERFORMED? YES NO T 20a EXTERNAL CAUSE WAS 20b. DESCRIBE HOW NIURY OCCURED (Enter nature of in ury in Part Lor Part II of item 18.) PRIMARY TO OF CONTRIBUTING 20c TIME OF INJURY Month Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f. (City or lown) Hour a.m. While Not While Fectory, street, office bldg., etc.) (County) (State) While \_\_\_Not While et work at work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection 📆 Inquiry Y and in my opinion death resulted from: Natural causes . Accident . Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DATE SIGNED please execute should be for ID IUNERAL Health or its d SIGNATURE July 31, 1967 DEPUT Benedict Skitarelic, M.D. Cumberland, Md. NAME (Type) Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) 22a, BUR AL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Bar al Cen. Granisville, Farrett, 23. EMNERAL DIRECTOR VR AISME Grantsville, Md. 5M 1/62



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 38929 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE **b** COUNTY ALLEGANY MARYTAND ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 DAYS ECKHART d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? MINERS HOSPITAL YES NO X 3 NAME OF Middle Lost 4 DATE First Month Doy Year DECEASED ent, MILDRED JULIA KIRBY JULY 1967 (Type or print) DEATH S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER I YEAR 7. MARRIED NEVER MARRIED birthdoy) Doys Hours FEMALE WHITE DEC. 2, 1915 WIDOWED A DIVORCED in any 12 CITIZEN OF WHAT 100 LSJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11, 8iRTHPLACE (County & Stote, or foreign country) HOUSE WORK U.S.A. OWN HOME signed by the attending physician burial-transit permit Then please burial, crematian, ar remaval, and MARYLAND 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME CLARENCE BONE ANNA MAY DAVIS IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) [(If yes give wor or dotes of service) 217-10-5070 WM. R. KIRBY, ECKHART, MD. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO A PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg , etc.) Not While at work 21. I certify that (I) (this haspital) attended the deceased fram from the deceased alive an from causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. r, page be filed 22d. ADDRESS 22c PHYSICIAN'S A. PAICE STRONG, M. D. NAME (Type) E. MAIN ST., FROSTBURG, MD. directar, should l 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION, 23b DATE THEREOF (County) (Stote) BUHTA (Specify) JULY 12 167 ST. MICAHELS CEMETERY FROSTBURG, MD. 2So. REC'D BY REGISTRAR 24 FUNERA, DIRECTOR 25b. REGISTRAR'S SIGNATURY JOSEPH R. DURST, SR., FROSTBURG, MD. 20 M 1/66

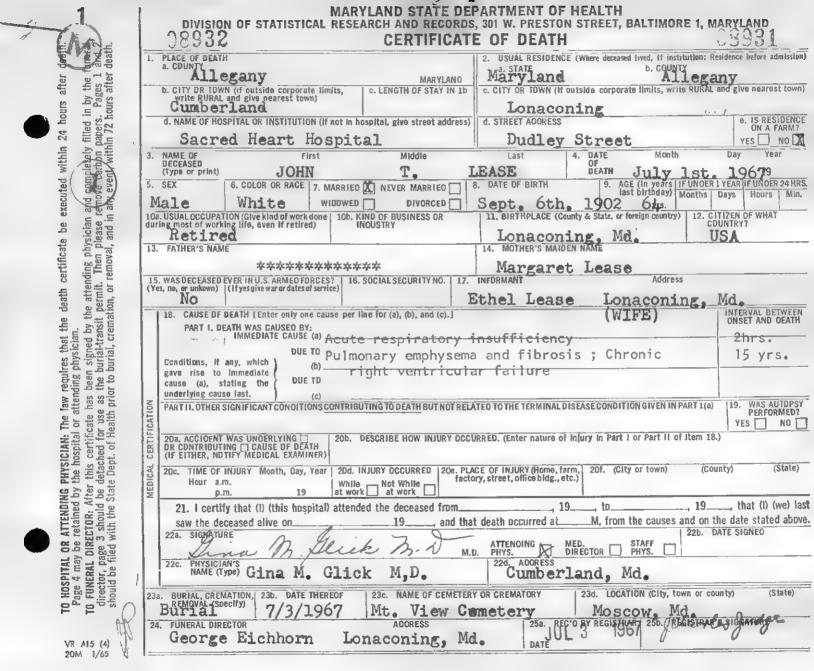


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. COUNTY o. STATE b. COUNTY Maryland Allegany Allegany after death. MARYLAND b CITY OR TOWN ( f outside carparate limits r TENGTH OF STAY IN TH ( CTY OR TOWN ( flouriside corporate in ts, write RURAL and give nearest town) write RURAL and give nearest town) 10 Days Cumberland Cumberland d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES, DENCE hours Item 18. Give Pages 1, Office alang with form ON A FARM? Note Memorial Hospital 317 N. Centre Street NO te havrs after death 3 NAME OF First Middie .0st 4 DATE Month DECEASED Koegel July 19 67 (Type or print) Regina Mav DEATH S SEX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED B DATE OF BIRTH lost birthdoy) Months Days DIVORCED White MIDOWED Jan 7, 1900 Female 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 106 KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CIT ZEN OF WHAT COUNTRY? n penal in Examiners ( Shoemaker Cumberland Maryland U.S.A. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ⊑ Lucy Lattinger gup Dawson Brant 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address 634 Shriver Ave ird "pending" in Chief Medical E (Yes, ng. or unknown) (Cyes give wor or dotes of service) remayal 214-05-9463 Cumberland, Md Eugene Brant INTERVAL BETWEEN 4B CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY DEL VIAND DEATH Pulmonary Emboli ь IMMEDIATE CAUSE (o) ward This certificate should cremation, **DUF TO** Fracture of Left Hip 10 Days Conditions flony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse used as burial, c 19. WAS AUTOPSY PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? CERT F CATION NO A agent, priar to 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18.) Page 4 shauld Fell at Home CAUSE OF DEATH. 20c TIME OF INJURY Month, Doy, Year 20d NURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hone Not While While While of work pm July 3 19 67 Cumberland, Alleg. Maryland ot work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspect on 🛣 ], Inquiry 🕱 and in my apinion death resulted fram: Natural causes Accident X Suicide Hamicide | Undetermined manner the funeral director. CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MED CAL EXAMINER K July 12. 1967 **EXAMINER'S** Address (Street, city, town or coulcomberland. Mabyland Health Benedict Skitarelic. M.D. NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) 0 REMOVAL (Specify) 7/15/67 Greenmount Cemetery Cumberland Alleg Maryland
Y REGISTRAR 25b, REGISTRAR'S SIGNATURE 2So REC D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15ME (5) H. Lee Silcox 404 Decatur Cumberland, Md 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08931 CERTIFICATE OF DEATH within 24 haurs after death the attending physician and campletely filled in by the funeral sit permit. Then please remave carbon papers. Pages 1 apd PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed, if institution, Residence before admission) a. COUNTY b. COUNTY ALLEGANY MARYLAND ALLEGANY c. LENGTH OF STAY IN 15 b. CITY OR TOWN (If autside corporate limits, c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RJRAL and a ve nearest town) 4 DAYS FROSTBURG KROSKBURG d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) e IS RES DENCE ON A FARM? d. STREET ADDRESS MINERS HOSPITAL YES | NO S WASHINGTON 3 NAME OF First Middle. DATE Lost Manth Doy (Type or print) JOHN KROLL DEATH event, requires that the death certificate be executed SEX 9 AGE ( n years 6 COLOR OR RACE 7. MARRIEO OATE OF BIRTH NEVER MARRIED lost birthday) Manths Doys Haurs or removal, and in any MATE WHITE WIDOWED DIVORCED 1880 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR 10a US., AL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working the even (retired) COAL COUNTRY? MARYLAND FROSTBURG: II.S 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME HERMAN KROLL ANNA LAPP 15 WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT FROSTBURG MD. (Yes no ar unknown) (If yes give war ar dates of service) crematian. IB. CAUSE OF DEATH (Enter only one couse per line far (o), (b), and (c)) INTERVAL BETWEEN burial-transit ONSEL ANO DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' signed by DUE TO Canditians, if any, which gove rise ta immediate cause (a). DUE TO as the stating the underlying cause has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION for use Health p NO O FUNERAL DIRECTOR: After this certificate YES Page 4 may be retained by the haspital ar 20o ACCIDENT WAS UNDERLYING . 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Not While ot wark at work July 15, 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased from Let 19 6 Za ta. shauld 15 19 67, and that death accurred at 7 M. from causes and on the date stated above. saw the deceased alive an. 22o. SIGNATURE 22b. OATE SIGNED ATTENDING STAFF director, page 3 should be filed v MD. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) JOHN B. DAVIS, M.D. BROADWAY director, BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) FROSTRURG 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATUR 25b VR A15 (4) 1 20 M 1/66 DATE







MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08932 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the ottending physician and completely filled = by the funeral sit permit. Then please remove carbon pagests. Pages Nand a. STATE a. COUNTY b. COUNTY ALLEGANY ALLEGANY MARYLAND c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside corporate I m ts CLENGTH OF STAY IN 16 write RURAL and give negrest\_town CUMBERLAND 6HRS. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d. STREET ADDRESS STREET MEMORIAL HOSPITAL ARCH NO T YES T DATE 3 NAME OF Middle First Last Year DECEASED JULY 22 LEWIS MAYNARD WILLIAM DEATH (Type or print) AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS S. SEX B. DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** pst\_birthday) Haurs 9-13-1894 WHITE MALE **G3WODIW** DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) VIRGINIA-Stephen City USA RETIRED 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME NANNY CHAPMAN CLARENCE LEWIS 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. HOSPITAL, CUMBERLAND, MD. (Yes, no, or unknown). (If yes give wor or dates of service) MEMORIAL no INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per lime for (o), (b), and (c) PART | DEATH WAS CAUSED BY: buriol-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if ony, which gave rise to immediate couse (o), DIJE TO stating the underlying cause os the be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate hos been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) for use NO 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I at Part II af item 18.) 200 ACCIDENT WAS UNDERLYING detached for the Dept. of 1 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 204- (City or town) (Caunty) (Stote) 20c, TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, offura bidg., etc.) of work 21. I certify that (I) (this haspital) attended the deceased fram. and that death accurred at 12:50, from layres and on the date stated allove saw the deceased alive an 291 SIGNATUR 22b. DATE SIGNED STAFF PHYS. M.D. DIRECTOR PHYS 22d. ADDRESS 122 SO. ST. CUMBERLAND CENTRE DR.R.J director, 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) 23g. BURIAL, CREMATION, REMOVAL (Spepty)
Burial Stephen City, Va. Green Hill Cemetery 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. VR A15 (4) 20 M 1/66



2, 1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
<u> </u>	: 53:	08934 CERTIFICATE OF DEATH
after death		1. PLACE OF DEATH a. COUNTY  ALLEGANY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, 1f Institution: Residence before admiss b. COUNTY  MARYLAND  ALLEGANY
hours f in hy	death certificate be executed within 24 hours to attending physician and completely filled in by permit. Then please removekaghon papers. Pation, or removal, and in any event, within 72 hours.	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  CUMBERLAND  C. LENGTH OF STAY IN 1b  46 DAYS  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  CUMBERLAND  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ted within		3. NAME OF DECEASED (Type or print) FLOSSIE S. LILLER DEATH JULY 3 19 67  5. SEX G. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24) to the thirth days.
exec		FEMALE WHITE WIOOWEO DIVORCED 3'26'02 65 yrs. Months Days Hours M.  10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INOUSTRY OWN HOME GORMANIA, WEST VIRGINIA U.S.A.  13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
death certific		WILLIAM SHIRCLIFF  PLEASANT (SMITHX)  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Ifyes Give war or dates of service)  NO  PLEASANT (SMITHX)  Address SETON DRIVE  220-16-5941-4 HOSPITAL RECORDS CUMB., MD. 21502
e +		18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c) PART I. DEATH WAS CAUSED BY:  CONGESTIVE HEART FAILURE  DUE TO  Conditions, If any, which gave rise to Immediate cause (a), stating the Council of Conditions (a), stating the Council of Conditions (b)  OUE TO UREMIC POISONING  INTERVAL BETWEL CONGESTIVE HEART FAILURE  OUE TO ARTERIOSCLEROTIC HEART DISEASE  10 YRS.
The or a	of Health pric	cause (a), stating the UREMIC POISONING underlying cause last. (c)  PARTIL DIHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a)  PERFORMED YES NO  20a. ACCIDENT WAS UNDERLYING  CONTRIBUTING CAUSE OF DEATH ITE EITHER, NOTIFY MEDICAL EXAMINER; NONE
NNG PHYSI d by the ho	State Dep	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, officebldg., etc.)  While Not While at work 19 at work 19 at work 21. I certify that (I) (this hospital) attended the deceased from MAY 18, 19 67, to JULK 3, 19 67, that (I) (we)
TO HOSPITAL OR ATT Page 4 may be reta	director, page 3 should should be filed with the	stry the deceased alive on 301 3 . 19 5 , and that death occurred at 4 M, from the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Several Research State of the causes and on the date stated about 22a. Sever
VR AII	5 (4)	23a. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BURIAL JULY 7,1967  FROSTBURG MEMORIAL PARK FROSTBURG, MD. 24. FUNERAL DIRECTOR BYRON KIGHT  CUMBERLAND, MD.  DATE JUL 7: 1967  LOCATION (City, town or county) (State)  COUNTY COUNT

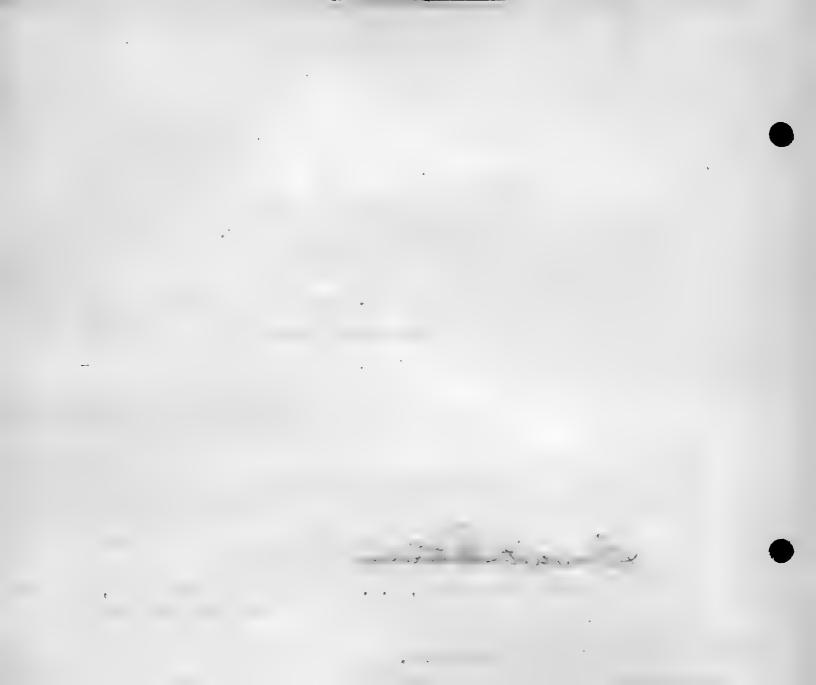
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 08935 requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY Allegany b. COUNTY Allegany Maryland MARYLAND b CITY OR TOWN (if patside corporate limits c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Cumberland Cumberland d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) B IS RESIDENCE d STREET ADDRESS Allegany County Infirmary 121 Bedford Street YES 🗀 NO TV Middle 3 NAME OF 4. DATE First Day Year DECEASED (Type or print) OF DEATH Lippold Clara 67 Marv July 19 DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED pirthdoy) Months Dovs Haurs 5/24/1882 White Female WIDOWED DIVORCED KIND OF BUSINESS OR INDUSTRIA INCLUSION TDo USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Repired: Housekeeper for Cumberland. Maryland Hotel 14. MOTHER'S MAIDEN NAME 13. FATHER 5 NAME ar remaval, Daniel Bradley Ellen Joyce 17. INFORMANP. O. Box 599. Cumberland, Md. 21502 IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no. grunknown) (If yes give wor ar dates af service) Allegany County Infirmary records. 214-05-8013 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signad by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) 11. 1 01 DUE TO Canditians, if any, which gove rise to immediate cause (o), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending as the has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) of far use NO this certificate 20g ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Hame, form, (State) 2Dd. INJURY OCCURRED (City or town) (County) 20c TIME OF INJURY Manth, Day, Year Hour a.m factory, street, office bldg., etc.) Not While O FUNERAL DIRECTOR: After \_\_\_, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 3/ and that death accurred at P. /67 M, fram causes and an the date stated above. saw the deceased alive an 22g. SIGNATURE 22b. DATE SIGNED STAFF PHYS. 7/11/1967 X X M.D. DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS Memorial Hospital, Cumberland, Md. NAME (Type) Topper, M. D. directar, p John 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (Caunty) 23o. BURJAL CREMATION (Stote) REMOVAL (Specify) Hillcrest Burial Park Cumbrland. Allegany Burial REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR victories VR A15 (4) DATE H. Lee Silcox 401 Decatur St. Cumb. Md



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before a finitision) a. COUNTY **b** COUNTY Allegany Maryland Allegany MARYLAND b. CITY OR TOWN lif outside corporate 1, mits, & LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate I m ts, write RURAL and give neerest fown) write RURAL and give nearest town Cumberland 50 years Cumberland d NAME OF HOSPITAL OR INSTITUTION ,s. not in hospital, give a real eads as d STREET ADDRESS 315 Pennsylvania Avenue 315 Pennsylvania Avenue YES NO X 3 NAME OF Mida DECEASED (Type or print) Walter W. Logue DEATH 5. SEX 6 COLOR OR RACE, 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 19 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday] + Months Male Dec. 22, 1915 W DOWED -DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Sie e or foreign country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working lile, aven il retired) Self Employed Cumberland, Md. B aker USA 13. FATHER'S NAME William Theodore Logue Myrtle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECUR TY NO. 17 INFORMANT Address (Yes, no, or unkown) [ (Ifyesgivewerordelesofservice) Mrs. Marie Logue, Cumberland, Md.-Wife War II yes 18. CAUSE OF DEATH [Enter only one couse per line for (e), b), and (c) INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY: CORONARY OCCLUSION IMMED ATE CAUSE (e) 4301 DUE TO SCLEROSIS CORONARY Conditions, if any, which geve rise to immediate cause DUE TO (e), stetling the underlying PART II. OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, lenter neture of injury in Part I or Part II of Jem IB.) PRIMARY | or CONTRIBUTING | wr ting to Chief A CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stelle) lectory, street, office b dg , etc.) Hour em. While Not While at work | at work 21. I certify that I took charge of the remains described above, held an Autopsy [ ]. Inspection T and n my opin.on Natural causes death resulted from: Surcide Undetermined manner Acendent Homicide CHIEF MEDICAL EXAMINER July 14 lease exect should be for FUNERAL ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) SKITARELIC, M.D. Address (Street, city, town, or county) CUMBERLAND. MARYLAND 220 BURIAL CREMATION! 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) <u>0</u>40 ± Mt. Hermn Cemetery Buril Cumberland, Md. Allegany 23. FUNERAL DIRECTOR ADDRESS 246 REC'D BY REGISTRAR | 246 REGISTRAR'S SIGNATURE VR A15ME James F. Scarpelli, Cumberland, Md. 5M 1/62

ATE DEPARTMENT OF REALTH



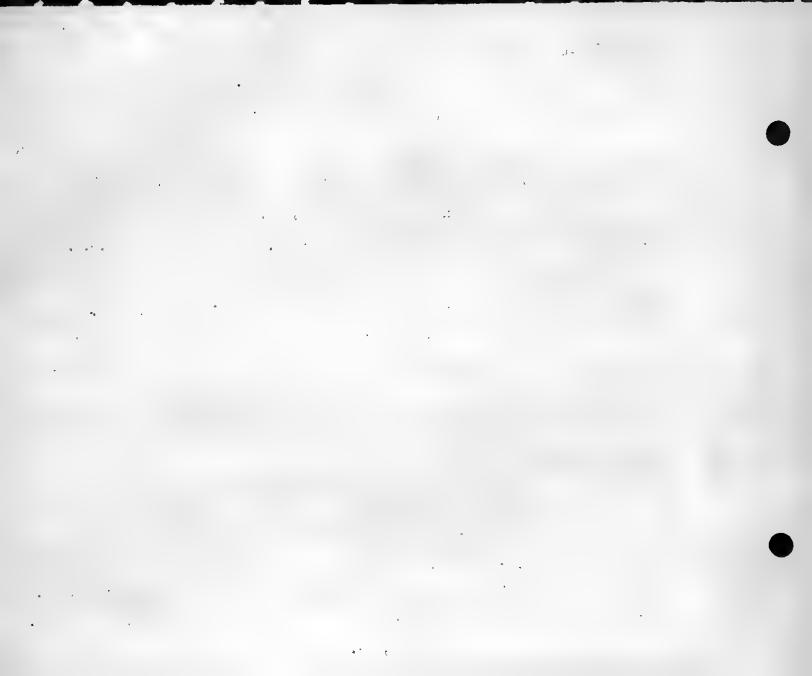
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 98937 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) e. COUNTY o STATE b COUNTY ALLEGANY ALLEGANY MARY, AND b CITY OR TOWN (If outside corporate fimits, CLENGTH OF STAY IN 4h c City OR FOWN (If outside corporate timits, write RURAL and give necrest town) after TITE MI. SAVAGE (SLABTOWN) d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, a ve street oddress) d STREET AODRESS 6 IS RESIDENCE ON A FARM? hours YES NO X ofter death 3 NAME OF Midd e Frst LOST 4 DATE Month Dov Year DECEASED PAIIT MARTIN JULY W. 2, 1967 (Type or print) DEATH S SEX 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED X NEVER MARRIED 8 DATE OF BIRTH 64 pirthdoy) Months Days MATE WHITE MARCH 8. 1903 W DOWED OIVORCED event puo 100 SUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (State or foreign country) 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT MARYLAND gages In any pencil 13 FATHER S NAME 34. MOTHER'S MAIDEN NAME NORA DAVIDSON ARMOND MARTIN pub 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address 15 WAS OLCEASED EVER IN U.S. ARMED FOR THE CONTROL OF SERVICE 216-03-8942 be executed permit. removol MRS. MARTHA TRULY, MT. SAVAGE, MD. INTERVAL BETWEEN IB. CAUSE OF OEATH (Enter only one couse per line for (o), (b), and (c). PART I, DEATH WAS CAUSED BY CONSET AND OFATH IMMEDIATE CAUSE (o) Ward ficate shauld motion, **OUE TO** Conditions, if ony, which gove rise to immediate couse (a), DUE TO 0 stoting the underlying couse lost. used as burial, WAS AUTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) NO DE 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) agent, priar 3 should PRIMARY I or CONTRIBUTING I AL EXAMINER: CAUSE OF DEATH 20c TIME OF INJURY Month, Ooy, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form (City or fewn) (Stote) (County) foctory, street, office bldq, etc.) FUNERAL DIRECTOR: Poge of work ot work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection X. Inquiry X. and in my apinion deoth resulted fram-Natural causes Accident | Suicide X Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATUR the funerol O DEPUTY pe p DEPUTY MEDICAL EXAMINER **EXAMINER'S** BENEDICT SKITURELIC MARDESS (Street, city, town, or could eoith NAME (Type) 23b DATE THEREOF 23d. LOCATION (City or Town) 23o. BUR.AL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 0 METHODIST CEMETERY JULY 5, 1967 MT. SAVAGE. MD ADDRESS 24. FUNERAL DIRECTOR VR AT SME 15 JOSEPH R. DURST, SR., FROSTBURG, MD. DATE 6M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08938 MEDICAL EXAMINER'S PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. COUNTY b. COUNTY Maryland Allegany Allegany MARYLAND b CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) C LENGTH OF STAY N TO c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) 4½ years Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? in Item 18. Give Pages 1, r's Office along with form 24 Browning Street YES NO 32 24 Browning Street The Storage 3. NAME OF 4. DATE Middle Doy Year McCain DECEASED Alvin Jesse July 67 (Type or print) DEATH 19 c F 9 AGE ( n years S SEX 6 COLOR OR RACE B DATE OF BIRTH IF UNDER 24 HRS K 7 MARRIED NEVER MARRIED 3 7 Jost birthdoy) Months Dovs Nov. 19, 1894 Male White WIDOWED DIVORCED event 11. BIRTHPLACE (State or foreign country) IDo. USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life even itretired)
Retired Lt. Guard COUNTRY? Printing Office-Lafayette, Ala. USA rd "pending" in pencil in Chief Medicol Exominer's 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME William Jackson Mc Cain Ada Elizabeth Reed File ond IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (f yes give wor or dotes of service) removal. Mrs. Grace Fleming, Cumberland, Md. INTERVAL BETWEEN 1B CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c).) buriol-transit PART I. DEATH WAS CAUSED BY: Occlusion Coronary 6 .MMEDIATE (AUSE (o) This certificate should cremation, DUF TO Sclerosis Coronary Conditions, if ony, which gove rise to immediate couse (a). **DUE TO** stating the underlying couse burial, 19 WAS AUTOPSY PART 1, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? NO 3 agent, prior to 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port I of term IB) CERT Page 4 should PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. 2Dd →N.JRY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work Health or its designated Inquiry X. 21. I certify that I took charge of the remains described above, held on Autopsy Inspection X ond in my opinion Notural couses Accident | deoth resulted from Spicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MED CAL EXAMINER SIGNATUR moy be re FUNERAL I DEPUTY MEDICAL EXAMINER **EXAMINER'S** BENEDICT SKITARELIC, M.D. Address (Street, city, town, or county CUMBERLAND. NAME (Type) 230 THAME OF SEMETERY OR FREMATORY PATTE 23d LOCATION (City or Town) 230 BUR AL CREMATION 23b DATE THEREOF (County) 90 REMOVAL (Specify) July 12,1967 Allegany Cumberland . Md . BEIN MANY 8 CAMPHON Buria 24 FUNERAL DIRECTOR 256 REC'D BY REGISTRAR 2Sb REG STRAR S SIGNATUR James F. Scarpelli, Cumberland, Md. VR A15ME (5) 6M 1/66



1	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Q ?
FOR STATE	08939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY Allegany  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Allegany
sary heral	b. CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
fun fun may may	rural westernport 14 dats Moscow Mills
delay incessary, and 3 to the funeral Page 5 may be, State Department, hours after death,	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  a. IS RESIDENCE ON A FARM?  YES \( \sum_{NO} \)  NO \( \sum_{NO} \)
The San de	3. NAME OF First Middle Last 4. DATE Month Day Yeer OF DECEASED (Type or print) Everett Wilson McCarty DEATH July 28 1967
三一 [ ]	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   FUNDER 1 YEAR   FUNDER 24 HRS. last birthdey) Months   Days   Hours   Min.
f. 8 2 7 2	Male White Widowed Divorced June 1, 1877 90 yrs.
Give Pa Give Pa ng with s 1 and ny event	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Our penter  10b. Kino Of Business or industry INDUSTRY Self employment  Penna.  11. BirthPlace (State of foreign country) COUNTRY? U. S. A.
ours aften 18. Gi	13. FATHER'S NAME
24 hou litem Office File p	Henry McCarty Not Known
1. a E	15. WAS DECEASED EVER IN U.S. ARMEO FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)
within pencil in miner's permit.	no O Charles McCarty-Westernport, Md.
"pending" in period of the following in period of the following in the following in the cremation, or ret	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1  PART I. DEATH WAS CAUSED BY: Coronary Oculsion  IMMEDIATE CAUSE (e)  OCULSION
ing calling the training training the training training the training training the training train	Tears Years
le e pend pend fedil	gava rise to immediate (b)
a be eff	cause (a), steting the DUE TO underlying cause last.
nte mhoure word he Chie	(V)
Treate the the to but to but	PERFORMED? YES NO 🔀
EXAMINER: This cardificate about the electral within 24 hours after death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, hould be forwarded to the Chief Medical Examiner's Office along with formios.  18. Page 3 should be assed as a burial-transit permit. File pages 1 and 2 mm signated agent, prior to burial, cremation, or removal, and in any eventuithin	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTO-ST PERFORMED?  YES NO ST PRIMARY OF CONTRIBUTING OF CONTRIBUTIN
This shot shot	
Ge 3	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 120f. (City or town) (County) (State)  Hour a.m. While Not While at work 120 at wo
the certificate the certificate the certificate the should be in files.  CTOR: Page designated	21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion
the cert should r files. TOR: Pa designat	death resulted from: Natural causes 56. Accident , Suicide , Homicide , Undetermined manner
	ACTUAL AC
Y MEDI execute Page I for you AL DIRI	SIGNATURE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 7/28/67
DEPUTY MEDI lease execute irector. Page stained for yo FUNERAL DIR f Health or itt	EXAMINER'S Rame (Type) Benedict Skitarelic Address (Street, city, town, or county) Cumberland, Md.
O DEPUTY please ex director. retained O FUNERA of Health	23d. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)
day of the Company of	Hurring (Specify) 7/31/67   Philos   Westernport, Md.
No	24. FUNERAL DIRECTOR  AOORESS  AOORESS  25a. REC'O BY REGISTRAR! 25b. REGISTRAR'S SIGNATURE  ALIG 2 1967  AUGUSTAN SIGNATURE
VR AISME (S)	Box Westernport, Md. OATAUG 2 1961 flames Just .



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201933 CERTIFICATE OF DEATH 38940 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH O COUNTLLEGANY O. STATE MARYLAND **b** COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside carparate imits, write PLPA, and give nearest town) c LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 14 DAYS requires that the death certificate be executed within 24 hau and campletely filled in b d STREET ADDRESS IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 405 MD, AVE.. SACRED HEART HOSPITAL-CUMB., MD. NO 7 y event, with 3. NAME OF Middle DATE First Month Year CLOSKEY BEULAH 19 67 DECEASED (Type or print) JULY 20 DEATH SEX 6 COLOR OR RACE WHITE B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** FEMALE 60 vrs 1-27-07 WIDOWED DIVORCED E 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CIT ZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done COUNTRY? during mass of water being period) INDUSTRY ALLEGANY, MARYLAND USA 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME WILLIAM E. REID ANNA (CADWALLADER WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no or unknawn) (If yes give war ar dates of service) ъ 214-05-5133 PT'S, HOSPITAL RECORD-SACRED HEART HOSP IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b) NTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions if eny, which gave rise to immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO YES for 200, ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I ar Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day Year factory, street, affice bldg., etc.) Not While at wark at work 21. I certify that (I) (this hospital) attended the deceased fram 2-6 be retained director, page 3 should should be filed with the 7-20 - 1907, and that death accurred 21,50 M, fram causes and an the date stated above saw the deceased alive ap-22b. DATE SIGNED 22a ATTENDING M.D. DIRECTOR PHYS 22d. ADDRES PHYSIC AN EARL R. PAUL, M.D. GREENE STREET CUMB., MD. 21502 NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL CREMATION, (County) REMOVAL (Specify) JULY 24,1967 HILLCREST BURIAL PARK CUMBERLAND REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERA, DIRECTOR **ADDRESS** 25a. VR A15 (4) 20 M 1/66 BYRON KIGHT CUMBERLAND, MD.



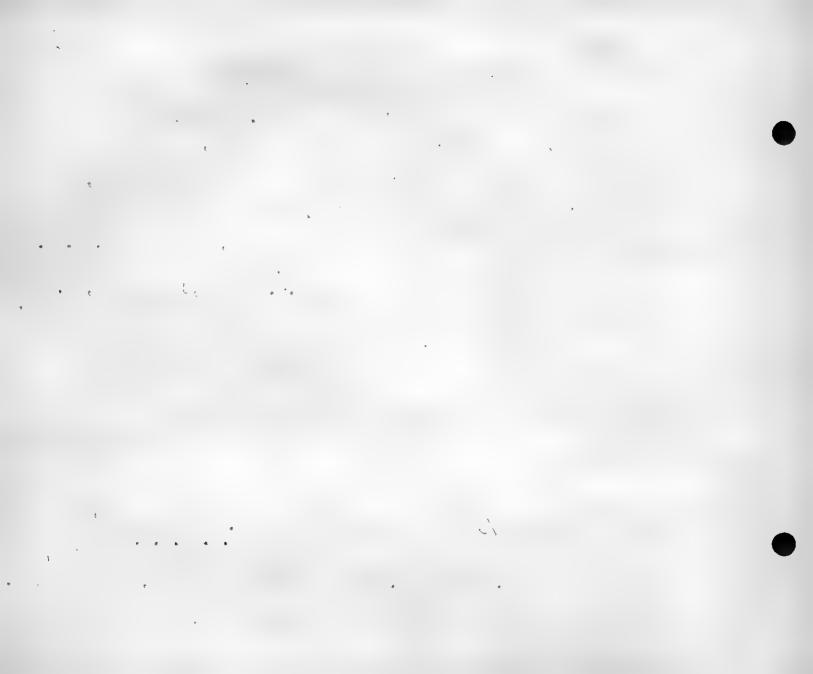
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212010 CERTIFICATE OF DEATH 08941 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Allegany o. STATE Maryland b. COUNTY Allegany The law requires that the death certificate be executed within 24 haurs after MARYLAND completely filled in by the f ove carban papers. Pages b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c TENGTH DE STAY IN 16 Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Allegany County Infirmary Polk Street NO N pan 3. NAME OF Middle Last 4 DATE Month Year DECEASED 67 Margaret McFarland July 10. Type or print DEATH DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE AGE (In years 7 MARRIED NEVER MARRIED birthday) Months 11/7/1872 Hours White Famale WIDOWED DIVORCED crematian, ar remaval, and in ar 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Own Home Moscow, Maryland Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Agnes McArthur David Tennant 17. INFORMANT P.O.Box 599, Cumberland, Md. 21502 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes. no. or unknown) If It yes a ve war at dates at service) Allegany County Infirmary records. None CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DEUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY PERFORMED? director, pagm 3 shmuld be metachmd far use shauld be filed with the State Dmpt. of Mealth NO 🕟 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH etachilid (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (County) factory, street, office bldg., etc.) at wark 21. I certify that (1) (this haspital) attended the deceased from Sept. 24, 19 59, to JULY 1967 saw the deceased alive an July and that death occurred at A. M., fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR ATTENDING STAFF PHYS. M July 10, 1967 M.D. + PHYS 22d ADDRESS 22c. PHYSICIANS NAME (Type) John Memorial Hospital. Cumberland. Md. Topper, M. 23a. BURIAL, CREMATION, BEMOVAL (Specify) 23d LOCATION (City or Tawn) 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 7/12/67 Hillcrest Burial Park Cumberland 25a REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Cumberland, Md. H. Waune George



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 38942 requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and ond 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH Maryland b. COUNTY Allegany Allegany o. COUNTY MARYLAND n 72 hours after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumborland c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/16/1966 Mt. Savage. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS completely filled in cover for bond papers. Allegany County Infirmary New Row. YES NO TY 4 DATE 3 NAME OF Middle Month Year First Lost Day DECEASED OF DEATH Elizabeth Mellotti 67 July Annie 19 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. AGE (In years S SEX DATE OF BIRTH 6 COLOR OR RACE 7. MARRIED NEVER MARRIED b rthdoy) Months Doys Hours White 2/23/1883 Female WIDOWED DIVORCED burial, cremation, or removal, and in any 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 1Do USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired)
Housewile Lonaconing. Maryland Home 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Thomas Rowan Mary Powers 17. INFORMANP . C. Box 599, Cumberland, Md. 21502 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes no, or unknown) (If yes give wor or dates of service) Allegany County Infirmary records. INTERVAL BETWEEN A 18 CAUSE OF DEATH (Enter only one couse per fine for (a), (b), and (c).
PART I DEATH WAS CAUSED BY signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physicion. DHE TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse **JUNERAL DIRECTOR:** After this certificate has been director, page 3 shauld be detached for use as the should be filed with the State Dept. of Health prior to lost. WAS AUTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 7 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 200 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) 2Dc. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While at work 21. I certify that (1) (this hospital) ottended the deceased from 5 1901 . that (1) (we) lost 1966 19 67, and that death occurred of P. \_M, from couses and on the date stated above D.S.T. 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S Memorial Hospital, Cumberland, Md. NAME (Type) Topper, Μ. John A 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230 BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burlal Long coning. Md. Allegany St. Mary's Cemetery 2 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Scarpelli, Cumberland, Md. YR A15 (4) 20 M 1/66

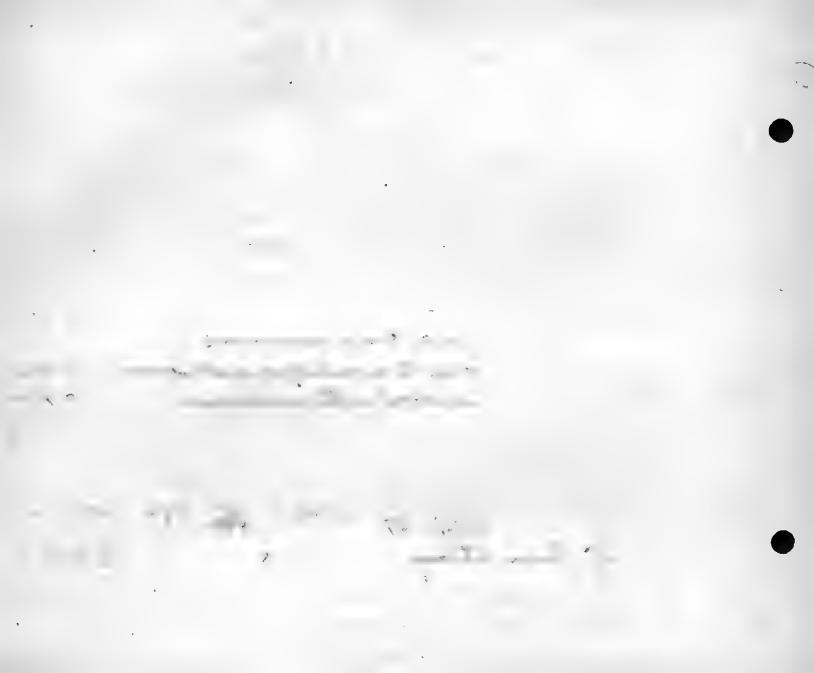
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08942 08943 CERTIFICATE OF DEATH The law requires that the death certificate be executed within/24 hours after death funerol : PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission O. STATE MARYLAND o. COUNTY **b** COUNTY ALLEGANY ALLEGANY MARYLAND and in ony event, within 72 hours aft b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town) write RURAL and give Berren LOWAND. 20 MINS. CUMBERLAND. MD. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? papers 122 POLK ST. MELORIAL HOSPITAL NO A 3. NAME OF Middle 4. DATE attending physicion and completely formit. Then please remove carbillin ME YERS ANNA DECEASED M. JULY 26 (Type or pnnt) DEATH DATE OF FIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE NEVER MARRIED 7. MARRIED last bythdoy) 7-3-08 FEMALE WHITE WIDOWED DIVORCED 10b KIND OF BUSINESS OR 11. BIRTH: LACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done during most of working life, even if-retired) INDUSTRY Own Home U.S.A. CUMBERLAND. MD. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, cremation, or removal, THOMAS GRADY LAURA THOMAS 16. SOCIAL SECURITY NO. 17 INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service MEMORIAL HOSPITAL CUMBERLAND, MD. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH ACUTE CONGESTIVE HEART FAILURE IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove CHRONIC MWORARDITIS rise to immediate cause (a), **DUE TO** stoting the underlying couse (1) ARTERIOSCLEROTIC GARIOVASCULAR DISEASE 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NOV Poge 4 moy be retained by the hospital ar O FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED WE G factory, street, office blda., etc.) Hour 'o.m. of work 670 M, fram causes and an the date stated abave 21. I certify that (I) (this haspital) attended the deceased fram. JAN director, page 3 should should be filed with the JULY 26 19 67, and that death occurred saw the deceased alive an 22a. SIGNATURE MED DIRECTOR STAFF PHYS M.D 22c PHYSICIANS 22d CUMBERLAND. MD. NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOYAL (Specify) July 28,1967 Greenmount Cemetery Cumberland .Md . Allegany 9 250 REC'D BY REGISTRAR 198756 REGISTRAR'S S GNATUR Scarpelli, Cumberland, Md. 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67

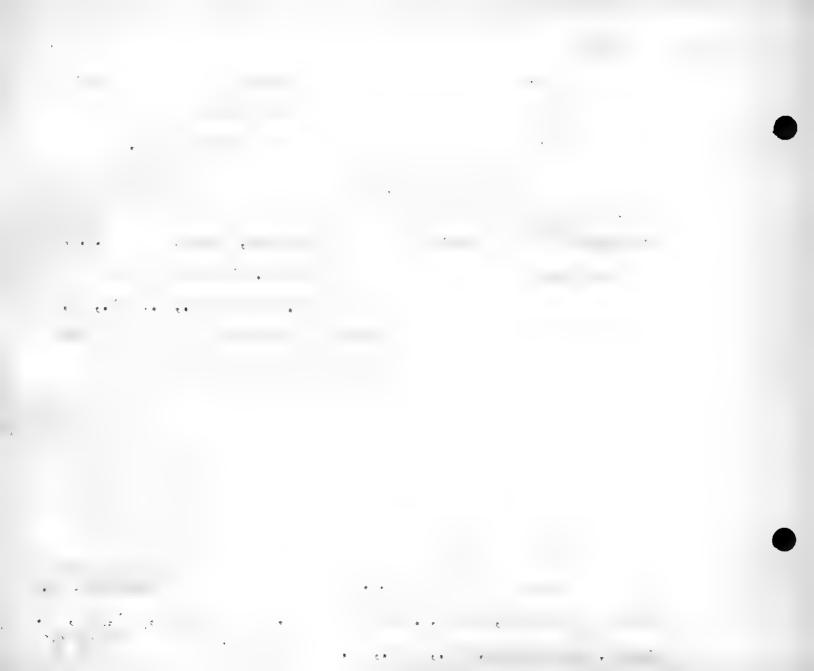


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth. Pages 1 ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. COUNTY a COUNTY Allegany Allegany MARYLAND the death certificate be executed within 24 hours after filled in by the b CITY OR TOWN (If outside corporate limits. CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RJRAL and give nearest town)
Frostburg hours Frostburg 6 Days popers hin 72 ho d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? Miners Hospital Beall Street YES NO K corban pc 3 NAME OF Middle Lost 4 DATE Manth Day DECEASED Joseph M. Miller July (Type or print) DEATH 9. AGE (In years S SEX IF UNDER I YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH remoyé last\_birthday) Manths Days WIDOWED DIVORCED Male White March 16,188b 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind at work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY? INDUSTRY City of Frostburg Allegany Maryland Employee 13. FATHER'S NAME Lawerance Miller Mary Martin WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war ar dates of service) 220-07-6941 Nο Mrs. Viola Miller 20 Beadl St. NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: requires that IMMEDIATE CAUSE (o) physician. DUF TO Conditions, if only, which gave rise to immediate cause (a). DUE TO stating the underlying cause os the prior to O FUNERAL DIRECTOM: After this certificate has been WAS AUTOP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Health p PERFORMED? NO Poge 4 moy be retained by the hospitol or 20a. ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Hour a.m. factory, street, affice bldg., etc.) Not While at work at wark 19.67, that (I) (we) last 2) I certify that (1) (this haspital) attended the deceased fram \_\_\_\_\_\_\_ plnous 1967, and that death accurred at 5 12M, fram causes and an the date stated above. saw the deceased alive an 22a, SIGNATURE 22b. DATE SIGNED ATTENDING K DIRECTOR PHYS director, page 3 M.D. PHYS. 22d. ADDRESS 22c PHYS:CIAN'S NAME (Type) Frostburg . Md . East Main 23g. BURIAL CREMATION 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) owers Funeral Home JUL b 1967 Sh. Main, Frostburg Pare Frostburg Alleygany Md. Buria er-Sowers Funeral VR A15 (4) M. Sowers 20 M 1/66





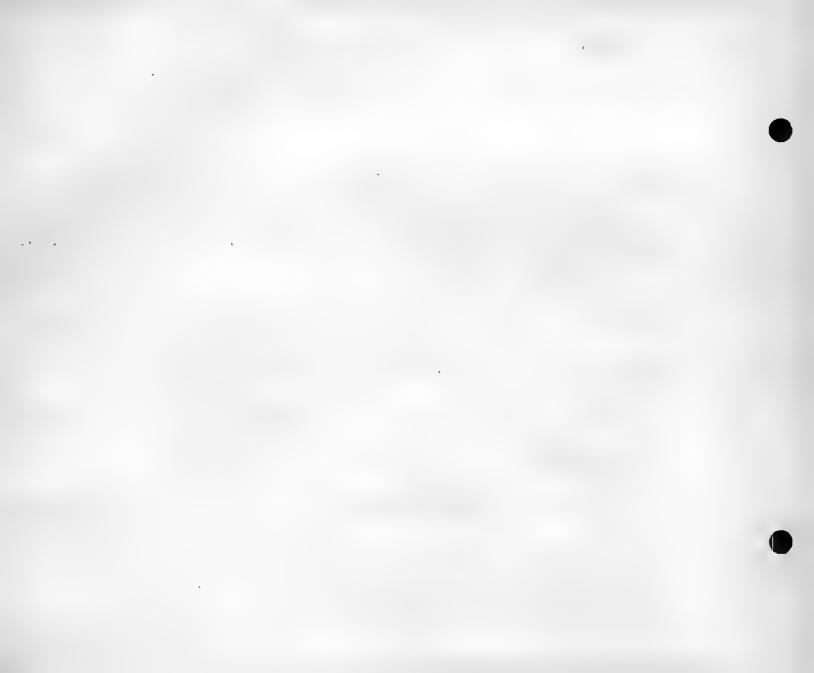
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 08946 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, functifulion, Residence before admission) o. COUNTY o. STATE b. COUNTY P.M.3. Page Allegany Maryland Allegany of o MARYLAND ond 3 c CITY OR TOWN (If auts de carporate limits, write RURAL and give nearest town) b C.TY OR TOWN (If guitside corporate I mits, c . ENGTH OF STAY IN 1h write RURAL and give negrest town) 1 Day Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 20 form State De Memorial Hospital 36 Pennsylvania Ave. Give Poges YES NO K after death 3 NAME OF F ist Middle 4 DATE Last Manth DECEASED MINKE July 17 19 67 JOHN FRANCIS DEATH S SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years FUNDER 24 HRS 7 MARRIED NEVER MARRIED birthday) Hours June 24, 1898 Male White W DOWED DIVORCED 10a USUAL OCCUPATION (Give kind af work done 11 BIRTHPLACE (State or foreign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) poges 1 in ony ( Cumberland, Maryland Millwright 13 FATHER'S NAME 14 MOTHERS MAIDEN NAME be executed with John Minke Mary C. Hipshman IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. or remayol. (Yes, no, or unknown) (If yes give wor or dotes of service Lottie H. Minke 36 Pa.Ave. Cumb. Md. 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c),) INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY Cerebral Hemorrhage IMMEDIATE CAUSE (a) used as a burial-tra bur.al, cremation, a writing the word DUE TO Hypertensive Cardiovascular disease Conditions, if ony, which gave rise ta immediate cause (a). DUE TO stating the underlying couse PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS: PERFORMED? oge 3 should be u NO I 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW MINDRY OCCURRED (Enter nature of injury in Part I or Part II of item 18) PRIMARY Or CONTRIBUTING STEAL EXAMINER: CAUSE OF DEATH. 20e, PLACE OF INJURY (Home, form, 20c TIME OF INJURY Manth, Day, Year 20d IN. JRY OCCURRED (City or town) (Caunty) Nat While factory, street, office bldg., etc.) at work al work 2). I certify that I took charge of the remains described above, held an Autopsy Inspection **X**, Inquiry 📆 , and in my opinion Natural causes Xi. Accident . Suicide . death resulted from: Hamicide . Undetermined monner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY July 17, 1967 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Benedict Skitarelic. 5 may 10 FUNE Address (Street, city, town, or county) Cumberland, Md NAME (Type) 23a. BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) (State) Burial (Specify) July 20,1967 S.S.Peter & Paul Cem. Cumberland, Allegany, Md. 24. FUNERAL DIRECTOR VR ATSME (5) Philip B. Wendt 121 Mem. Ave. Cumb. Md.



, 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201								
		08947		CERTIFICATE	OF DEATH		08946		
offer death the function gest for offer after death		PLACE OF DEATH O. COUNTY ALLEGA b. CITY DR TDWN (If outside co	rporote imits,	MARYLAND	o STATE	here deceosed lived, if institut on b. COUNTY	ALLEGANY		
e executed within 24 haurs after deat and campletely filled in by the function remove carbon papers. Pages on a nany event within 72 hours after deat		Write RURAL and give neore CUMBE RLAN d. NAME OF HOSPITAL DR INSTI	TUT ON (If not in hospital	, give street oddress)	d. STREET ADDRESS RT 2	BOX XX 179	e is residence Dn a farm? Yes \( \) NO \( \)		
uted withii mpletely fi gy carbon	3.		PEARL OR RACE 7. MARRIED	-	MORGAN  B. DATE OF BIRTH		Day Year 1967  FUNDER 1 YEAR   IF UNDER 24 HRS Anniths   Doys   Hours   Min.		
te be exection and capes temoral and in any	dur	USUAL OCCUPATION (Give kind on most of working life, even if r	HITE WIDOWED of work done etired)	DIVORCED NIVORCED NIV	2-23-1920  11 BIRTHPLACE (County & SOMERSET)	Stote, or foreign country)	12. CITIZEN DE WHAT		
certificate b g physician + Then please maval, and i	13.	FRIEDLINE,			14. MOTHER'S MAIDEN NA AURA GROSS	5			
he death cer e attending p permit. The	IS. (Ye	S. WAS DECEASED EVER IN J.S. ARMED FORCES?  16 SOCIAL SECURITY NO.  17 INFORMANT  MEMORIAL HOSPITAL, Address  CUMBERLAND, MD.  18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c))							
The law requires that tatending physician. has been signed by the se as the burial-transit		PART I. DEATH WAS CAU	DUE TO  DUE TO  DUE TO  DUE TO  DUE TO	rassive Pulm rassive Pulm rebothromb		pules -	INTERVAL BETWEEN ONSET AND DEATH		
	CERTIFICATION	PART II DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)  Phile among the significant conditions contributing to death but not related to the terminal disease condition given in Part 1(o)  Phile among the significant conditions contributing to death but not related to the terminal disease condition given in Part 1(o)  19. Was autopsy performed?  YES NO  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
DING PHYS by the has lifter this ce be detache State Dept.	MEDICAL	20c. TIME OF INJURY Month, Hour o.m. p.m.	Doy, Yeor 20d. Whi 19 of we		E DF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City or town)	(County) (Stote)		
TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the haspital or TO FUNERAL DIRECTOR: After this certificate directar, page 3 shauld be detached far us shauld be filed with the State Dept. af Healf		saw the deceased alive an Luck 1967, and that death accurred atM, fram causes and an the date stated obove 220. SIGNATURE  M.D. ATTENDING MED							
O HOSPITAL Page 4 may O FUNERAL   directar, pag shauld be fil	230	DESCRIPTION SEA	3b. DATE THEREOF	23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City or Town)			
12 3	24	REMOVAL (Specify) OULT AL FUNERAL DIRECTOR	7-11-67	Sunset Memor	ial Park 250. RECID	Cumberland, J	Allegany Md.		
VR A15 (4)		H. Lee Silcox	404 Dec	atur St. Cumb. 1	1 1	17 12 12 12 12 12 12 12 12 12 12 12 12 12			



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 BRRAY CERTIFICATE OF DEATH 08948 The law requires that the death certificate be executed within 24 haurs after death by the funeral 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH Allegany o COUNTY g STATE b. COUNTY Maryland allegany MARYLAND c LENGTH OF STAY IN 16 b CITY OR FOWN (If autside carparate limits, c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give negrest town 3 months CUMBERLAND IS RESIDENCE ON A FARM? d NAME OF HOSPITAL DR INSTITUTION (if not in haspital, give street address) d STREET ADDRESS campletely filled in popers Sylvan Retreat 610 Fairview Ave. YES NO X NAME OF Middle 4. DATE Month Last Day Year /3 DECEASED 0F Margaret Mollan 1957 Josephine July ent (Type or print) DEATH IF UNDER 24 HRS SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** remaye last birthdoy) Months Doys Hours Female White WIDOWED JULY 16.1887 DIVDRCED burial, crematian, or removal, and ın any gud 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) 10o USUAL OCCUPATION (Give kind of work done during most of warking the even if retired) COUNTRY? attending physician sermit. Then please U.S.A. Allegany Co., Maryland HOME 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Enoch McKenzie Margaret Rohman 17 INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war at dates of service NONE CUMBERLAND, MD. PAUL MULLAN INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) signed by the burial-transity ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **0 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse ue aetached for use as the State Dept. af Health priar ta last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO O FUNERAL DIRECTOR: After this certificate ATTENDING PHYSICIAN: 20g ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (County) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) 20c. TIME OF INJURY Month, Dov. Year foctory, street, office bldg., etc.) Hour o.m. Nat While at work , 19<u>67</u>, ta July , 19<u>67</u> , that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased fram. director, page 3 should should be filed with the and that death occurred at 7 P. M. fram causes and an the date stated above 1967 saw the deceased alive on. 22b. DATE SIGNED SIGNATURE 22a MED DIRECTOR STAFF PHYS M.D PHYS 22d ADDRESS PHYSICIAN S NAME (Type Simons 0 23d. LOCATION (City or Town) BURIAL, CREMATION, 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) PETER & PAUL CEMETERY CUMBERL AND. MD 24. FUNERAL DIRECTOR **ADDRESS** REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 BYRON KIGHT CUMBERLAND. MD.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 68943 CERTIFICATE OF DEATH usurd the funeral ages 1 and 2 rs after death. requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE b COUNTY ALLEGANY ALLEGANY completely filled in by the fur love carbon papers. Pages 1 y event, within 72 hours after MARYLAND b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) 40 DAYS FROSTBURG FROSTBURG IS RESIDENCE ON A FARMO d NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS 45 S. WATER STREET MINERS HOSPITAL YES NO\* NAME OF Middle 4. DATE Year 7 Eirst Month Dov DECEASED MYERS JULY 11. ANNA Κ. DEATH (Type or print) S SEX 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. **NEVER MARRIED** birthdoy) Hours AUG. 21, 1863 REMALE WHITE MIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10p USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & Stote, or foreign country) COUNTRYS . A. ON HOME during most of working life, even if retired)
HOUSE WORK MARYLAND attending physic permit. Then ple ion, or removal, c 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME NANCY BOWLIN WILLIAM THOMAS IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) i(If yes give was or dates of service) MABEL MYERS, FROSTBURG, MD. 220-52-9657-11 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the buriol-tronsit p burial, cremati ONSET AND DEATH HRONIC BRAIN SYNDROME IMMEDIATE CAUSE (o) CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause by the hospitol or offending IO FUNERAL DIRECTOR: After this certificate has been the lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3 should be detoched for use with the Stote Dept. of Heolth NO C YES 20¢. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (Stote) (County) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour o.m. Not While of work of work 21. I certify that (1) (this haspital) attended the deceased fram tene 2, 1962, to Jecla 11, 1967, that (1) (we) last saw the deceased alive an 1962, and that death accurred at 9:254M, from causes and an the date stated above. 22b. DATE SIGNED 22a, SIGNATURI ATTENDING TO HOSPITAL OR director, page 3 shauld be filed v M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS E 22c. PHYSICIAN S MAIN ST., FROSTBURG, MD. STRONG. M. D. A. PAIGE NAME (Type) 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BUR TAT FROSTBURG. MD. FB'G. MEMORIAL PARK 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE. 24. FUNERAL DIRECTOR Milarles JOSEPH R. DURST, SR., FROSTBURG, MD. VR A15 (4) 20 M 1/66

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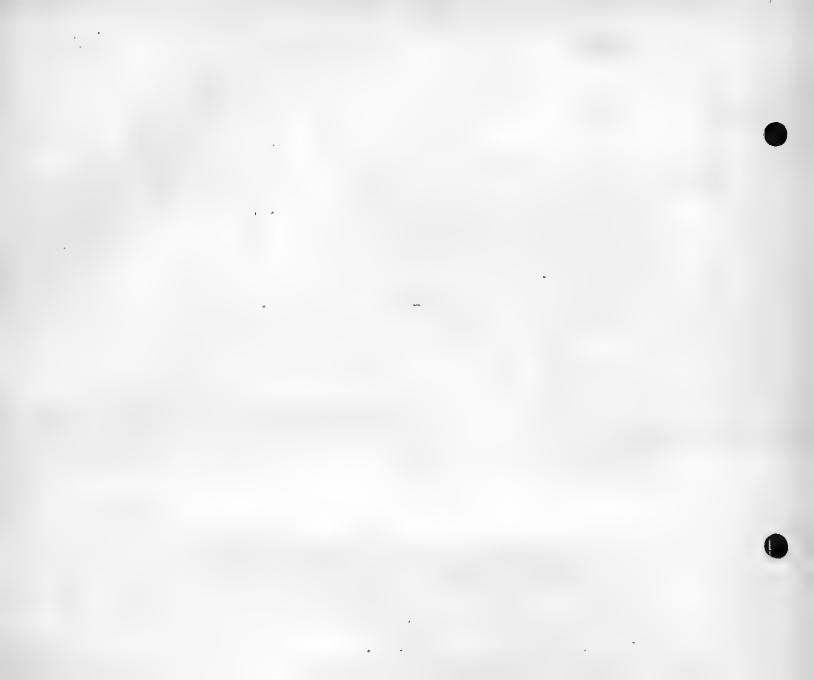
1		MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE		38950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68949
HEALTH DEATT	1.	PLACE OF DEATH  a. COUNTY Allegany  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. GOUNTY Allegany
24 hours after death. If any delay is cessary, in Item 18. Give Pages 1, 2, and 3 to the funeral Office along with form PM3. Page 5 may be File pages 1 and 2 with the State Department, and in any event whitin 22 hours after death,		b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)  write RURAL and give nearest town)  c. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)  Westernport  C. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)  Westernport
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  Kolbergs Hill  Kolbergs Hill  On A FARM?  YES NO
		NAME OF First Middle Last 4. DATE Month Day Year DECEASED (Type or print) Ethel Mae Myers DEATH July 2 19 67
		SEX 6. COLOR OR RAGE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  Female White WIDOWED DIVORCED Aug. 29, 1897  9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Min. Months Days Hours Min.
		USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired)  10b. Kind Df Business DR ing most of working life, even if retired)  11. BirthPlace (State or foreign country)  Maryland  12. Citizen Df What Country?  U.S.A.
		FATHER'S NAME William Emerson  14. MOTHER'S MAIDEN NAME Elizabeth Whiteman
within 24 pencil in It minmr's Offi permit, Fil	15 (Y	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 15. no. or unknown) (If yes give war or dates of service) Leonard H. Myers—Westernport, Md.
O DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hou please execute the certificate, writing the word "pending" in pencil in Item director. Page 4 should be forwarded to the Chief Medical Examinm's Office retained for your files.  O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File ping Health or its designated agent, prior to burial, cremation, or removal, and in		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (e)  Coronary occlusion  Stidden
		Conditions, if any, which \ (b) Coronary sclerosis
		gave rise to immediate cause (a), steting the DUE TO underlying cause last. (c)
	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED YES NO
		20a. EXTERNAL CAUSE WAS   20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of Injury in Pert 1 or Part II of Item 18.) PRIMARY   or CONTRIBUTING     CAUSE OF DEATH.
	MEDICAL	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20a. PLACE OF INJURY (Home, farm, Hour e.m.   While   Not While   Factory, street, office bidg., etc.)   PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   City of town) (County)   (State)   County   Cou
		21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes A, Accident, Suicide, Homicide, Undetermined manner
		ACTUAL SIGNATURE Benedict Sketarelic M.D. ASSISTANT MEDICAL EXAMINER 7-2-67 22. DATE SIGNED
	72	EXAMINER'S Benedict Skitarelic Address (Street, city, town, or county) Cumberland, Md.  BURIAL CREMATION, 23b, Date thereof   23c. NAME OF CEMETERY OR CREMATORY   23d. LDCATION (City, town or county) (State)
TO DE plea directa reta OF H	23	BEMOVAL (Specify) 7/5/67 Philos Westernport, Md.
VR AISME (5) 5M 1/65	24	ADDRESS STARR 25b. REGISTRAR'S SIGNATURE    25a. REC'D BY REGISTRAR'S SIGNATURE    DATE   UL 1 0 1967   Grant Signature   DATE   UL 1 0



MA Division of STATISTICAL RESEAR		PARTMENT OF HEALTH W. PRESTON STREET, BALTIM	ORE, MARYLAND 21201
08951	CERTIFICATE	OF DEATH	08959
PLACE OF DEATH COUNTY ALLEGANY	MARYLAND	2. USUAL RESIDENCE (Where deceased a. STATE MARYLAND	Nved, if institution Residence before admission) b. COUNTY ALLEGANY
b. CITY OR TOWN (If auts de carparate I mits, write RURAL and give nearest tawn)  CUMBERLAND, MD.  d. NAME OF HOSPITAL OR INSTITLTION (If not in hospital, give	tength of stay in 15 88 DAYS	CUMBERLAND, MC	limits, write RURAL and give nearest town)
SACRED HEART HOSPITAL	e street address;	225 FREDRICK ST	e is residence on a farm? Yes \( \) no \( \)
3 NAME OF First DECEASED (Type or print) VIRGIE	Middle B.	Lost 4 DATE NAUGHTON DEATH	Manth Day Year <b>JULY 18</b> 19 67
S SEX 6. COLOR OR RACE 7 MARRIED FEMALE WHITE WIDOWED	DIVORCED	9-18-87	AGE (In years IF JNDER ) YEAR IF UNDER 24 HRS last birthday) Manths Days Hours Min
during most of warking life, even if retired) INDU OWT	of business or stry n Home	11. BIRTHPLACE (County & State, or fore CUMBERLAND, ALLE	COUNTRY
13. FATHER'S NAME IRA MOXLEY		14. MOTHER'S MAIDEN NAME LOUISE SPRINKL	
		SPITAL RECORD	Address
IB CAUSE OF DEATH (Enter only one cause per line for (a) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).	PEBRO VI.	+SCULAR A	ecident interval between onst and death of chesione
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO	DEATH BUT NOT RELATED TO TH	Mellulus HE TERMINAL DISEASE CONDITION GIVEN	IN PART 1(a) 19 WAS AUTOPSY PERFORMED?
200 ACCIDENT WAS UNDERLYING   20b DESCR OR CONTRIBUTING TO YABUSE OF DEATH (IF EITHER, NOTIFE MEDICAL EXAMINER)  20c TIME OF INJURY Month, Doy, Year Hour a m. While I	RIBE HOW INJURY OCCURRED. (E	inter nature of injury in Port I or Port	YES NO 🔀
20c TIME OF INJURY Month, Day, Year 20d INJU While at work L  21 1 certify that (I) (this haspital) attended sow the deceased alive an 7 · / 7 -	RY OCCURRED 20e PLACE Not While at work foctor  d the deceased from	ry, street, affice bldg., etc.)	(ity or town) (County) (State)  (County) (State)  (County) (State)  (County) (State)  (County) (State)  (County) (State)  (State)  (A)  (County) (State)
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) ROBERT FEDDIS	M.O.	ATTENDING MED.	STAFF 22b. DATE SIGNED  7.19.67
	230 NAME OF CEMETERY OR CO		TION (Gity or Town) (County) (State) umberland Allegany Md.
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME -309 DECA	ADDRESS ATUR -CUMBERLAN	D_MD_ Date 11 9 / 10	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08951 08952 CERTIFICATE OF DEATH the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY **b** COUNTY ALIEGANY MARYLAND MARYTAND ALTEGANY b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG 3 DAYS FROSTBURG d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? MINERS HOSPITAL 164 BOWERY STREET YES NO T NAME OF Middle DATE Lost ′≩ campletely DECEASED VELMA ELIZABETH NEAL JULY 12. i, 19 67 (Type or print) DEATH IF UNDER 24 HRS SEX 6 COLOR OR RACE NEVER MARRIED A 8 DATE OF BIRTH 9 AGE (In years 7 MARRIED b rthdoy) Hours FEMALE MARCH 14, 1893 WHITE WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. 8IRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT **COUNTRY?** HOSPITAL MARYLAND U.S.A 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remaya ALEXANDER C. NEAL MARY ANN JACOBS 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address 15 WAS DECEASED EVER IN U.S. ARMED TO CLES. (Yes, no, or unknown) (If yes give war or dates of service) 217-14-4917 MISS NEDA K. NEAL, FROSTBURG. MD. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: The law reduires that IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ((o) 19 WAS AUTOPSY PERFORMED? NONE NO 🔀 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING [ be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home-form, 20c TIME OF INJURY Month, Day, Year (State) Hour om. foctory, street, office bldg, etc.) 21. I certify that (I) (this haspital) attended the deceased from 19 6 7 ta 1967 that (I) (we) los 1967, and that death occurred at Liso AM, from causes and an the date stated above DIRECTOR: saw the deceased alive an 220 SIGNATURE DIRECTOR M D TO HOSPITAL (Page 4 may b 22d ADDRESS 22c PHYSICIAN'S TO FUNERAL MARTIN M. ROTHSTEIN. NAME (Type) 48 BROADWAY, FROSTBURG, MD 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, (County) (Stote) JULY 15 167 FBG. MEMORIAL PARK FROSTBURG, MD. ADDRESS 2Sn RECD BY REGISTRAR 25b REGISTRAR 5 SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) JOSEPH R. DURST, SR., FROSTBURG, MD.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08952 CERTIFICATE 08953 OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) p. COUNTY ALLEGANY a. STATE b. COUNTY MARYLAND ALLEGANY MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If auts de comorate limits, write RURA) and give nearest town) write RURAL and or TWK 5 DAYS CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled i MEMORIAL HOSPITAL RT. YES NO Middle NAME OF First 4. DATE remove carban Last Month Year DECEASED (Type or print) 28, 19 LESTER PATTERSON JULY 67 8. and in any event. DEATH IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** B. DATE OF BIRTH AGE (In years Sythday) 2-22-1908 Months Days WHITE WIDOWED DIVORCED gug 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT, ZEN OF WHAT INDUSTRY KEYSER, W. VA. USA CELANESE

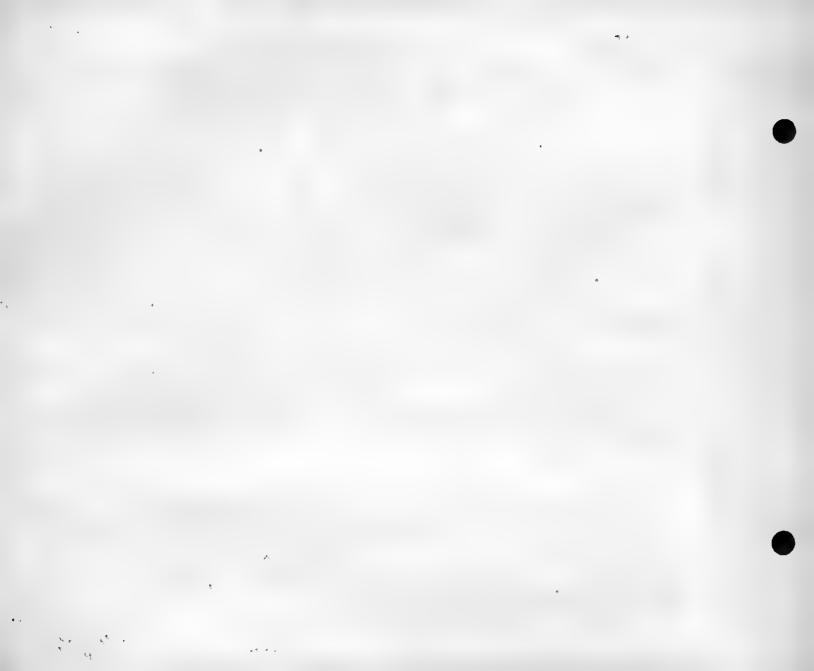
13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME crematian, ar remayal. SAMUEL PATTERSON MARY ARMENTROUT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war ar dates af service) 214-07-3359 MEMORIAL HOSPITAL CUMBERLAND No 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ò Page 4 may be retained by the haspital ar attending physician. DUE TO signed ! Conditions, if ony, which gove (b) rise to immediate cause (a). DUF TO stating the underlying cause be detached far use as the State Dept. af Health priar ta has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? YES I NO T certificate 20p ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part For II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20F (City or town) (County) (State) Hour to m Not While foctory, street, office bldg., etc.) at wark ot wark 21. I certify that (1) (this hospital), attended the deceased fram. and that death occurred at 6:30 A from couses and an the date stated above O FUNERAL DIRECTOR: saw the deceased glive an 22b DATE SIGNED 22a SIGNATURE director, page 3 should be filed w DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) DR. R. SCHINDLER CUMBERLAND, MARYLAND 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL CREMATION (County) REMOVAL (Specify) July 31, 1967 Queens Point Cem. Keyser, W. Va. Burial 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 DATE AUG Michaeles Keyser, W. Va.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 08954 requires that the death certificate be executed within 24 haurs after death. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY SOMERSET ALLEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) WELLERSBURG 10HRS 45MIN CUMBERI AND IS RESIDENCE ON A FARM? the attending physician and campletely filled in sit permit. Then please remove carbon passers. d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (if not in hospita), give street address) MEMORIAL HOSPITAL NO PC YES Middle NAME OF First 4 DATE Lost Month Doy Year DECEASED OF DEATH JUL Y 16. HARVEY **POORBAUGH** 6 19 ar removal, and in any event. DATE OF BIRTH AGE (In years S SEX 6 COLOR OR RACE NEVER MARRIED burthdoy) Months Dovs Hours WHITE MALE 7-24-1875 WIDOWED DIVORCED 13 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR rte, even if retired) Construction USA Schellsburg . Pa. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME SARAH BLUBAUGH WILLIAM H. POORBAUGH 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 217-03--0859 MEMORIAL HOSPITAL, CUMBERLAND, MD. directar, page 3 should be detached far use as the burial-transst perr should be filed with the State Dept. af Health priar ta bunal, crematian, INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)).
PART 1 DEATH WAS CAUSED BY: burial-transet ONSET AND DEATH IMMEDIATE CAUSE (a) þ Page 4 may be retained by the haspital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO signed Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse lost PART 11, OTHER ASSOCIATION CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS PERFORMED? NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port/II of item 18) 20a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED factory, street, office bidg., etc.) rank dagy , that (1) (we) lost 21. I certify that (I) (this hospital) attended the deceased from\_ 1967 10 196 7, and that death accurred at 11:48 Proble causes and on the date stated above sow the deceased alive an\_ 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS. 22d. ADDRESS PHYSIC!AN'S MIRKIN CUMBERLAND. MARYLAND NAME (Type) 23d LOCATION (City or Town) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, Co. Pa July 20. 1967 Mt. Lebanon Cemetery Berlin. RD#1. Somerset 25b. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR Hyndman, Pa. 196 VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 38956 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) PLACE OF DEATH D. COUNTY o. STATE b. COUNTY ALLEGANY BEDFORD MARYLAND on popers. Poges i c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) t LENGTH DE STAY IN 16 b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) requires that the death certificate be executed within 24 hours af-DAYS 1WK EVERETT - RURAL CUMBERLAND filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS S RESIDENCE ON A FARM? RT. MEMORIAL HOSPITAL NO A Middle 4 DATE 3 NAME OF Year 7 LOST completely JUL DECEASED PRICE ANNA GRACE (Type or print) DEATH AGE (In years S SFX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH lost pirttiday) Months Dovs Hours 2-13-1914 WHITE FEMALE WIDOWED cremation, or removal, and in ony DIVORCED 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? INDUSTRY USA EVERETT, PA. HouseWife 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME ANNA GRIMES JOHN H. CALHOUN IS WAS DECEASED EVER IN U.S. ARMED FD.RCES? 16. SDCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. 177-24-8859 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) ONSET AND DEATH buriol-tronsit signed by DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO storing the underlying couse os the prior to b Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) director, page 3 should be detached for use should be filed with the State Dept of Heolth has been under come Dr. Thomas huis NO [4 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy Year Hour o.m. Not While foctory, street, office bldg, etc.) ot work ot work 21. I certify that (1) (this hospital) attended the deceased from 19 7, and that death accurred at 1967 , that (1) (we) last 4:20 from causes and an the date stated above saw the deceased alive an 7-14 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR STAFF PHYS. ATTENDING 7/16/67 M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BRINSFIELD CUMBERLAND. MARYLAND CARL 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) 230 BURIAL, CREMATION REMOVAL (Specify) 7/18/67 W. Prov. Twp., 8ed. Co., Pa. Mt. Union Cemetery 2So REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) Everett, Pa. 20 M 1/66



ixision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admiss on) e. COUNTY e. STATE b. COUNTY Allegany MARYLAND c. CITY OR TOWN (if outside corporate I mils, write RURAL and give nearest fown) b. CITY OR TOWN (if oulside corporete limits, c. LENGTH OF STAY IN 16 write RURAL and give neerest town)  ${ t McCoole}$ McCoole d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 46 Howard Street YES NO Home Howard Street 3. NAME OF DECEASED DATE Morth OF (Type or print) DEATH Howard Percy Ravenscrof 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months WIDOWED DIVORCED [ Male 6 9 yrs. 10a. USUAL OCCUPATION (G ve kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stelle or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Retired B.& O. Eng. McCoole IIId U.S.A. pages 13. FATHER'S NAME Walter Edgar Ravenscroft Ida Belle Clark 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | [Ifyesgivewerordatesofservice] NO NO 705-09-727 Donald H. Ravenscroft, McCoole, Md. INTERVAL BETWEEN Son ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CORONARY OCCLUSION IMMEDIATE CAUSE (e) SUDDEN DUE TO CORONARY SCLEROSIS if eny, which (b) gave rise to immadiate cause **DUE TO** [a], steting the undarlying Examiner cause lest. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? 8 cremaf Medical should be NO T 20s. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH. ص <del>و</del> 20c. TIME OF INJURY 969 Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or Iown) (County) (Stete) Whila \_Not While fectory, street, office bldg., etc.) the R: Pa et work | el work execute the cert ficate, to th 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry X and in my opinion LDICAL forwarded DIRECT death resulted from: Natural causes XX Homicide Undetermined manner CHIEF MEDICAL EXAMINER **ACTUAL** ASSISTANT MEDICAL EXAMINER should be for DATE SIGNED designai SIGNATURE DEPUTY DEPUTY MEDICAL EXAMINER July 25. EXAMINER'S Address (Street, city, town, or countfumberland, IAd. NAME (Type) Benedict Skitarelic arelic M.D. Add 22a, BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or country) [Stete] REMOVAL (Specify) 40 Burial Vesternort Md. 23. FUNERAL DIRECTOR VS. A15ME 5M 9.60

ARYLAND STATE DEPARTMENT OF HEALTH



CORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Division of STATISTICAL RESEARCH C". IFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institutions Residence before admis. 1. PLACE OF DEATH a. COUNTY Maryland Alle, any Allegany MARYLAND b. CITY OR TOWN of outside corporate I mits, c LENGTH OF STAY IN 16 c. C.TY OR TOWN (If outside corporate I mits, write RURAL and in vernearest fown write RURAL and give nearest fown) 80 years Cumberland Cumberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addition) d. STREET ADDRESS Kinch Nursin: Home-506 Maryland Ave. 609 Maryland Avenue 3. NAME OF DATE DECEASED (Type or print) Catherine Robinette DEATH Elizabeth July 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 19. AGE (In years HE UNDER 1 YEAR IF UNDER 24 HRS 8 lest birthdey) Months, March 27, 1878 WIDOWED TO D. VORCED Female 10s. USUAL OCCUPATION (Give kind of work | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (Stele or foreign country) 1.12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Housewife Own Home Fort Ashby, W. Va. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry J. Willison Robecca Douthitt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURTY NO. 17 INFORMANT (Yesn 99, or unkown) | (Ifyesgivewarordatesofservice) Mrs. Betty Dean, Cumberland, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a., (b., end (c.)) PART I. DEATH WAS CAUSED BY: Coronary Occlusion IMMEDIATE CAUSE (a) DUE TO Sclerosis Coronary Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW NURY OCCURED, (Enter nature of in any in Part L of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20d INJURY OCCURRED 20e PLACE OF INJURY [Home, farm, 201. (City or fown) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) al work al work 21 I certify that I took charge of the remains described above, held an Autopsy Inspection 🛣. Inquiry 🛣 Natural causes Suicide . Homicide death resulted from: Undetermined manner CHIEF MEDICAL EXAMINER lease executions in the second of the second ASSISTANT MEDICAL EXAMINER July 27, 1967 EXAMINER'S Cumberland, Maryland SKITAL TIO, M.D. NAME (Type) 228, BURIAL, CREMATION, 7 226 DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION City, town, or country; REMOVAL (Survity) **5**40 ₹ Fort Ashby Cemetery Fort Ashby, W. Va. Mineral C. 23. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR | 24b. REG STRAR'S SIGNATUR VR A15ME . Scarpelli, Cumberland, Md.

5M 1/62

YES NO TX

INTERVAL BETWEEN onset and death

> PERFORMED? YES NO X

> > (State)

and in my opinion

DATE SIGNED



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08958 08953 CERTIFICATE OF DEATH 24 haurs after deoth, by the funeral Pages onth 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH a. COUNTY ALLEGANY o. STATE b. COUNTY **ALLEGANY** MARYLAND MARYLAND b CITY OR TOWN (If outside corporate I mits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) WINTER PER RIVE PERUS TOWN) **50DAYS** MOUNT SAVAGE e IS RESIDENCE ON A FARM? filled to d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT MEMORIAL HOSPITAL YES NO F The law requires that the death certificate be executed within 3 NAME OF Middle 4. DATE OF Manth First Lost Year attending physician and completely sermit. Then please remove carban DECEASED 67 ROBY JUL Y Ε. MARGARET 19 DEATH (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH S SEX 6 COLOR OR RACE NEVER MARRIED 7 MARRIED 50st birthday) Months Davs Haurs □11-7-16 WHITE FEMALE WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY PENNA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME ANNA STEVANAS SAMUEL GRAY 17. INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, na, ar unknown) [(If yes a ve war or dates of service)] CUMBERLAND, MD. 172-18-1788 MEMORIAL HOSPITAL. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY. BARROMA, UTERUS WITH signed by IMMEDIATE CAUSE (a) DUE TO METASTASIS SMONTHS Canditions, if any, which gave BILATERAL Pulmo WARY rise to immediate couse (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe NO X YES [ þ 20o ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour a.m. Not While at work 21. I certify that (1) (this hospital) attended the deceased fram Nov. 1966, 190.47ta P. M. July 3, 1967, that (1) (we) last should ith the ? be retained M, fram causes and an the date stated above 19 67, and that death accurred at saw the deceased alive an 22g. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR director, page 3 should be filed a 22d. ADDRESS CUMBERLAND, MD. 22c. PHYSICIÁN'S NAME (Type) DR FAW JR. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23b. DATE THEREOF 23g BURIAL, CREMATION, Burial (Specify) Meyersdale. Som. Union Cometeri 96 2Sq. REC'D BY REGISTRAR FUNERAL DIRECTOR 25b REGISTRAR'S SIGNATURE Klastes VR A15 (4) 20 M 1/66



MARY AND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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# 225		PLACE OF DEATH	Ī	2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission	n)
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Pag Urst		WILLE RUNDERIA ND TOWN	39 DAYS	CUMBERLAND	
hot hot ho	$\vdash$	d NAME OF HOSPITAL OR INSTITUTION (IF not in nespital,	arve street address)	d STREET ADDRESS e 15 RESID	ENCE
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4 within older poly fill p		DECEASED (Type or print) ANGELA	H.	ROHMAN OF JULY 24 19	57
ond compler remove col	٤.	SEX 6 COLOR OR RACE 7. MARRIED		B. DATE OF BIRTH 190 9 AGE (In years   IF UNDER 1 YEAR   IF UNDER 1 AGE (In years   Months   Days   Hours	
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the death certificote be executed to otherwise of the otherwit. Then please remove colorion, or removal, and in any event	10c dur	USUAL OCCUPATION (Give kind of work done IDb King most of workpolite even if retired)	IND OF BUSINESS OR NOUSTRY CATERING	11 BIRTHPLACE (County - Stote, or foreign country)  CUMBERLAND ALLEGAN Y MD.  12. CIT ZEN OF WHAT COUNTRY? USA	
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th certificate b	10.	GEORGE HARTMAN		14 MOTHER'S WIDEN NAME ZABETH BENDER	
ottending pormit. The	15	WAS DECEASED EVER IN U.S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. 11	NFORMANT Address	
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IAN ficol for far far	TIFI	200 ACCIDENT WAS UNDERLYING [ 20b. DI	ESCRIBE HOW INJURY OCCURRED. (	(Enter nature of injury in Part I or Port II of item 18.)	
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H be	MED CAL		NJURY OCCURRED 200 PLAC	CE OF INJURY (Home, form, 20f (City or town) (Caunty) (	(Stote)
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DIN by be Sto		21. I certify that (I) (this hospital) atten	ded the deceased fram	clober, 1966, to. 24 July, 1961, that (1) b	wer
TEN Beld Fe		saw the deceased alive on 7 - 2	4 1967, and that	death occurred at // AM, from causes and on the date stated	labo
F S S S S S S S S S S S S S S S S S S S		220 SIGNATURE	- (	ATTENDING MED STAFE 22b DATE SIGNED	_
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# × 2 80 €		22c. PHYSICIAN'S	W.B.	401 DECATUR ST., CUMB., MD. 215	02
Poge 4 mo O FUNERAl director, p should be		NAME (Type) ANDREW STASKO			-
Poge 4 Poge 4 Girecto should	230	BURIAL, CREMATION, 23b. DATE THEREOF	23c NAME OF CEMETERY OR C	CREMATORY . 23d. LOCATION (City or Town) (County) (St	tote)
5 0 g 0 g 6		REMOVAL (Specify)  July 27,196		Paul Cemetery Cumberland, Ed. Allega	any
- V:2	2/	ELINEPAL DIRECTOR	ADDRESS	250 PEC'D RY PEGISTPAP 256 PEGISTPAP'S SIGNATURE	

James F. Scarpelli, Cumberland, Md.

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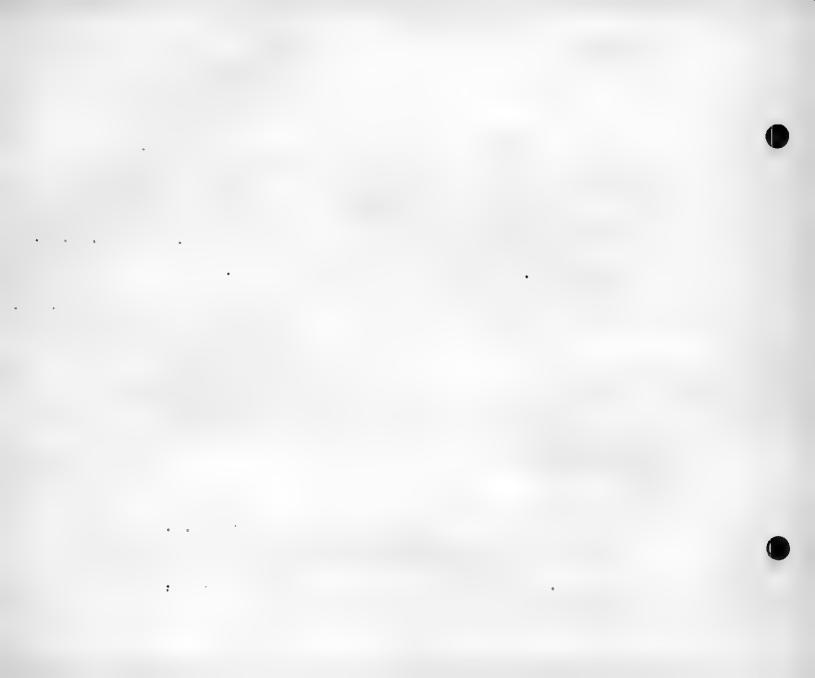
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08961 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. STATE p. COUNTY ALLEGANY b. COUNTY LEGANY MARYLAND sappy the sappy b. CITY OR TOWN (If outside cargorate limits. c LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neorest town) 30 CUMBERI AND CUMBERLAND IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS HOSP I TAL NO X YES MEMORIAL 3 NAME OF Middle 4. DATE First East Dov Year and completely en please remove carbad DECEASED BABY R001 event, GIRI JUL DEATH 19 67 (Type or print) AGE (In years IF JNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months Days Hours 7-18-67 and in any WHITE DIVORCED FEMALE WIDOWED KIND OF BUSINESS OR 10a HSUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) **12 CITIZEN OF WHAT** during most of working life, even if retired) INDUSTRY CUMBERLAND. MD. none 14 MOTHER'S MAIDEN NAME 13, FATHER'S NAME remayal, JAMES H. ROOT TONYA JEAN GRAY the attending p 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address 16 SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dotes of service) P MEMORIAL HOSPITAL. CUMBERLAND. MD none cremation. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line to)(o), (b), and (c) burial-transit ONSET AND DEATH DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO burial. Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse as the Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been last WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION be detached far use State Dept. af Health NO 🎜 YES F 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 1B.) 20o ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (1F EITHER, NOTIFY MEDICAL EXAMINER 20e, PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or town) (County) 20c, TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg, etc.) Not While OR ATTENDING at work at work 21. I certify that (I) (this haspital) attended the deceased fram 19\_\_\_\_, that (I) (we) last and that death accurred fram causes and an the date stated above saw the declased alive an. 220 SIGNATOR STAFF PHYS. MED DIRECTOR M.D. PHYS. Pa 22d ADDRESS PHYSICIAN S NAME (Type) LELAND CUMBERLAND. RANSOM directar, shauld b 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 23g BURIAL CREMATION REMOVAL (Specify) Comberland Allevany md SOMERINA 5-0 C FUNERAL DIRECTOR VR A15 (4) umberland, md 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

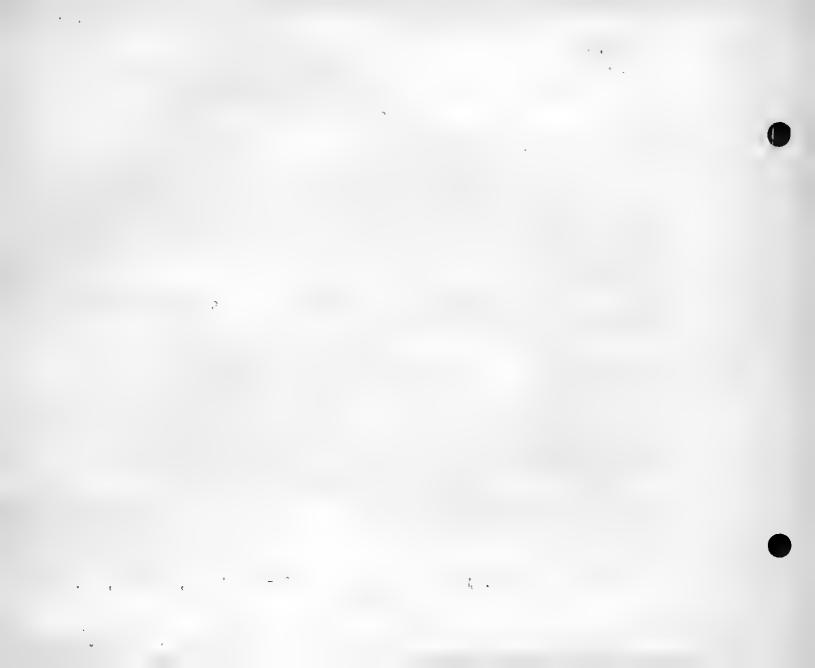
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08952 08863 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution: Residence before admission) o COUNTY o. STATE ALLEGANY MINERAL MARYLAND b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) CUMBERLAND CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) The law requires that the death certificate be executed within 24 haurs aft **KEYSER** 10 HOURS d STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL 413 VIRGINIA ST. YES 🗔 NO IX NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED 0F GIRL SAGAL JULY BABY 13 19 67 (Type or pnnt) DEATH 9 AGE (In years IF JNDER 1 YEAR IF JNDER 24 HRS S. SEX 6 COLOR OR RACE B. DATE OF BIRTH 7 MARRIED **NEVER MARRIED** remove last birthday) Manths Dovs 7/12/67 crematian, ar remayal, and in any FEMALE WHITE WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? please INDUSTRY ALLEGANY CO., MARYLAND 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME JOSEPH SAGAL : LINDA L. DOUGLAS 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes no ar unknown) (If yes give war ar dates of service) HOSP, RECORD SACRED HEART HOSPITAL NONE INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per lime for (a), (b), and (c)) al-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) signed by bur al-trans DUE TO Conditions if any, which gave nse ta immediate cause (o). DUE TO stating the underlying cause Health prior to <u>‡</u> 19 WAS AUTOPSY PERFORMED? PART I., OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 95 2 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B.) 20g ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Hour a.m. factory, street, office bldg., etc.) Nat While 21 I certify that (1) (this hospital) attended the deceased from. Page 4 may be retained director, page 3 should should be filed with the O FUNERAL DIRECTOR: saw the deceased alive an and that death occurred at M, fram causes and an the dote stoted above 22o. SIGNATURE MED DIRECTOR PHYS KATU 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) MIKIO RAXR. M/D/ 1225-B NATL HWY. LA VALE. MD. 21504 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION DATE THEREOF REMOVAL (Specify) 25g REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) duin



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in 72 h		MEMOR I	AL HOSPI		ive street address)		d STREET ADDRESS				e is residence On a farm? Yes No	
)	3	NAME OF DECEASED (Type or print)	EMO	γ γ	Middle F.		SHAFFER	4. DATE OF DEATH	Mor JUL		Doy Year 2, 1967	
		SEX MALE	6 COLOR OR RACE WHITE		NEVER MARRIED DIVORCED		DATE OF BIRTH		AGE (In years last birthdoy) yrs.	Months [		IRS.
o ui pur	10d dui	USUAL OCCUPATION	(Give kind of work done life, even it utired) Tinglield T	ire Co.	ND OF BUSINESS OR DUSTRY	Build	IN BIRTHPLACE (Count			12. C TIZ COUN	EN OF WHAT	
noval, and i	13	FATHER'S NAME WILLIA	M E. SHAF	FER			14 MOTHER'S MAIDEN					
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burial-transit permit. burial, crematian, ar r		18 CAUSE OF DE PART 1. DEAT	ATH (Enter only one cour H WAS CAUSED BY: IMMEDIATE CAUSE		(o), (b) and (c).)	677	2 < 4.				INTERVAL BETWEEN	·
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r af Ke	CERTII	20o. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b DE	CRIBE HOW INJURY OF	CCURRED. (	Enter noture of injury in	Port I or Port	II of item 18 }			
ofe Dep	MEDICAL	20c. TIME OF INJU Hour o.m	10	20d. IN While of work	JURY OCCURRED  Not While  of work	20e. PLAC focto	E OF INJURY (Home, for ry, street, office bldg , etc	m, 20f.	(City or town)	(Coun	ty) (Slote	e)
the Sto			y that (I) (this has	oital) attend	led the deceased 19 <u>6</u> 7.	from and that	death accurred a	196/ to t8:14M		2 , 19 6 and an the	that (I) (we) date stated a	last oave.
director, page 3 shauld be detached far use as the should be filed with the State Dept. at Health priar to		220. SIGNATURE	land.	Su	rill	M.D	7111125	MED DIRECTOR	STAFF PHYS.	22by DAT	E SIGNED	27
or, pag d be fill	L	22c. PHYSICIAN'S NAME (Type)		E. D	URRETT				AVE.		ERLAND,	M
shout	231	BURIAL, CREMATIO	July 4		23c. NAME OF CEME Hyndman ADDRESS			Hyno		dford (	ounty) (Stote)	_
director, page 3 shauld be detected as should be filed with the State Deg	K	ALLERAL DIRECTOR	V. Feirle	N	ADDRESS Hyndman, 1		1	D BY REGISTRA		EGISTRAR'S SIG	NATURE INCOME	24.00



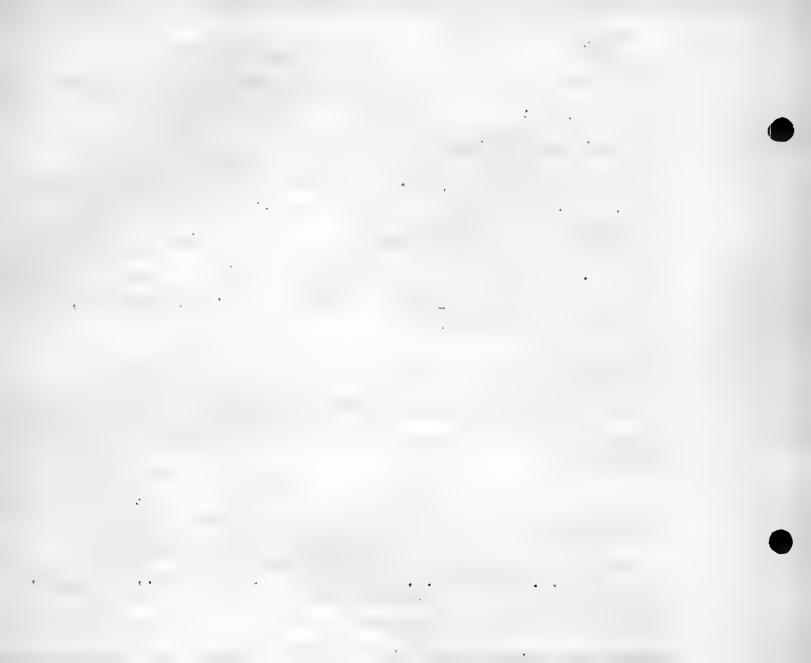
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 000/ 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) 1. PLACE DF DEATH a. CDUNTY b. COUNTY CHMBERLAND ALLEGANY **ALLEGANY** MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 17 DAYS CUMBERLAND, MD. 21502 CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) a. IS RESIDENCE d. STREET ADDRESS ON A FARM? AVE. POTOMAC PARK SACRED HEART HOSPITAL ND and completely i remove/carbon pi any event within executed within 3. NAME DE Month First Middle Last DATE DECEASED DOLLIE SHERMAN JULY 67 19 (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday)

Months Days Hours Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED FEMALE DIVORCED [ physician and ph 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 1Da. USUAL DCCUPATION (Give kind of work done 1 10b. KIND DF BUSINESS DR certificate be COUNTRY? during most of working life, even if retired) INDUSTRY MOOREFIELD, WEST VA. HWF. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME MARY POPE JESSE HEAVENER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. | 17. INFORMANT Address id by the attend transit permit. cremation, or n death (Yes, no, or unkown) (If yes give war or dates of service) PATIENTS HOSPITAL CHART 220\_10\_ 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN DNSET AND DEATH been signed by the burial-transit or to burial, crema PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY CERTIFICATION for use Health p PERFORMED? The certificate hospital or NO [ 2Da. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) t of DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (County) 2Dd. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While After d be d p.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should iled with the M, from the causes and on the date stated above. and that death occurred at saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE director, page Should be filed v ATTENDING -DIRECTOR \_\_\_ PHYS. FUNERAL 22d. ADDRESS PHYSICIAN'S 57 GREENE STREET, CUMBERLAND, MD.21502 BRINGS. M.D. 23c. NAME OF CEMETERY OR CREMATORY (State) 23d. LOCATION (City, town or county) BURIAL, CREMATION, REMOYAL\_(Specify) Moorefield, W. Va. 9 Olive Hill Cemetery Burial 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS Balto Ave., CumberlandDATE VR A15 (4) 20M 1/65

. 11 S SI T L .1 11 X . T2 , 71 7 , 1152,57

... S. 1. ... S. 1. ... S. 3. ...

<i>5</i> <1	1	MARYLAND STATE  Division of STATISTICAL RESEARCH AND RECORDS		PARTMENT OF HEALTH I W. Preston Street, Baltimore, Mai	RYLAND 21201
(NA				OF DEATH	08965
uneral uneral I and 2		PLACE OF DEATH D. COUNTY ALLE GANY MARYLAN	D	ΜΔΡΥΙ ΔΝΠ	ALLEGANY
haurs after death n by the funeral s. Pages I and haurs after death		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  CUMBERLAND  4 DAYS	)	c. CITY OR TOWN (IF outside corporate limits, write  FLINTSTONE	RURAL and give nearest town)
May had no 24 had no 24 had no 24 had no 72 ha		I. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  MEMORIAL HOSPITAL		d. STREET ADDRESS	e is residence on a farm? Yes \ no
ecuted within 24 ho		LA		OF DEATH  3. DATE OF BIRTH  9. AGE (In year lost burblete)	y) Manths Days Hours Min.
ertificate be exe physician and nen please refrio	10a dur	MALE WHITE WIDOWED □ DIVORCED □  USUAL OCCUPATION (Give kind of work dane pages of working life even if retired)  ME CHANGE SELF EMPLOYE	D	5-6-1915 52 y  1. BIRTHPLACE (County & Stote, or fareign country) PENNA	12 CITIZEN OF WHAT COUNTRY?
certifica g physic Then ple moval, c		JOHN T. SHIPWAY		14. MOTHER'S MAIDEN NAME BELLE SMITH	
that the death ce an. by the attending transit permit. Th	15 (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? s, no, or unknown) (If yes give wor ar dates of service)  Xes W W 2  16. SOCIAL SECURITY NO 213-30-0142		EMORIAL HOSPITAL, CU	MBERLAND, MD.
quires physici signed buriol-l buriol,		18 CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Candilians, if any, which gave nse to immediate cause (a), stating the underlying cause last	ne Leg	å Carcinon in left oro	afore ONSET AND DEATH
TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept. af Health prior to	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE			YES NO D
YSICIAN aspital a certifical hed for ot. af He	AL CERTIFICATION	OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		(Enter nature of injury in Part I ar Part II of item 18	
ING PH' by the h ter this we detact	MEDICAL	Hour a.m.  p.m.  19  While Not While of wark at work	facto	CE OF INJURY (Home, form, ary, street, affice bldg, etc.)  20f. (City ar tow	n) (County) (State)
ATTENDI TOR: Affinable bhauld bhauld bhath fith the S		21. I certify that (I) (this haspital) attended the deceased from the deceased alive an	that	t death occurred at 7:30 My fram cau	ises and on the date stated obove.  22b. DATE SIGNED
L OR A by be rely y be rely to INEC		22c PHYSICIAN'S	M.E	22d. ADDRESS	7/ 9/67
TO HOSPITAL Poge 4 may TO FUNERAL I director, pog shauld be fil	23	NAME (Typle) A. J. MIRKIN, M. D.  BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER	Y OR (		
10 HO POG 0 POG 17 F W 17	(2)	REMOVAL (Specify) 7/10/67 Piney Plai FUNERA DIRECTOR ADDRESS The J. Land Balto Ave., Cu	ns mbe	Cometery 250. REC'D BY REGISTRAR 250	Allegany Md.  B REGISTRAT'S SIGNATURE  YCharles June
20 111 1700		shn J. Hafer, Jr. 230 Balto Ave., Co		1	V



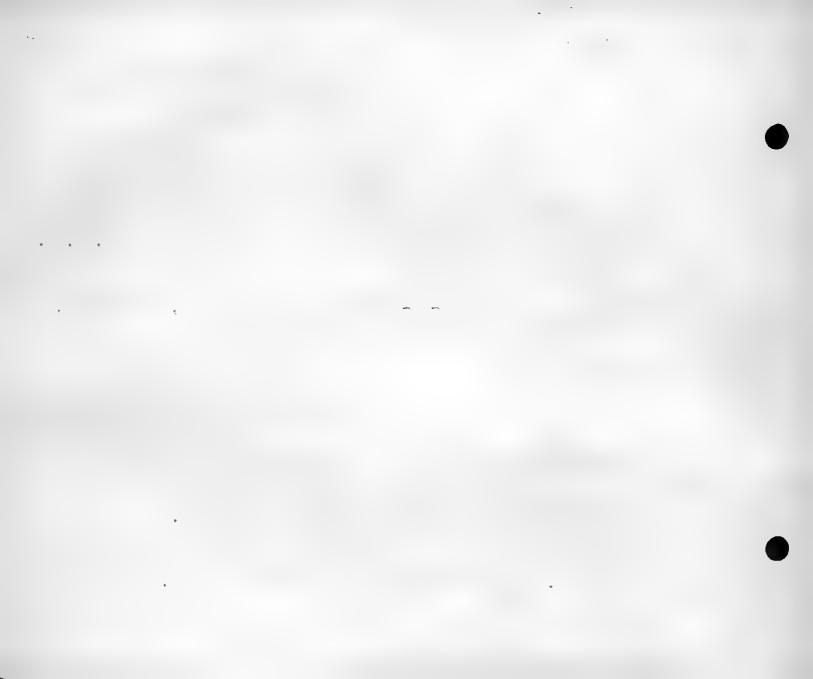
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08966 08967 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after-death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY o STATE **b** COUNTY MARYLAND **ALLEGENY** ALLEGANY lease remove/carban papers Pages I and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **CUMBERLAND** DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) = d STREET ADDRESS B IS RESIDENCE ON A FARM? MEMORIAL HOSPITAL 810 SUNBURY AVE. YES NO X NAME OF Middle First 4. DATE Month Lost Dov Year DECEASED (Type or print) EARL SINES JULY 24 67 DEATH 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED pirthdoy) Months 2-21-97 WHITE MALE WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, exept fretired) U COUNTRY? CUMBERLAND, MD. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. AARON SINES CARRIE HARDEN 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT årldress. (Yes, no, or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL. CUMBERLAND. MD. INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c)) signed by the buriaf-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH Coronary Occlusion IMMEDIATE CAUSE (o) 4201 DUE TO Conditions, if ony, which gave Coronary Arteriosclerosis rise to immediate cause (a), **DUE TO** stoting the underlying couse last PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS ALTOPSY PERFORMED? Hemorrhagic Anemia NO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 18.) 20o ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20e PLACE OF INSURY (Home, form, (City or town) 20d INJURY OCCURRED (County) (Stote) Hour o.m foctory, street, office bldg , etc.) Not While ot work of work TO HOSPITAL OR ATTENDIN Page 4 may be retained by 21. I certify that (I) (this haspital) attended the deceased fram July 23, 16,7195: 420 p. M. July 2419 67 that (I) (we) los director, page 3 shauld shauld be filed with the saw the deceased alive an Inly 21 19 67, and that death accurred at M, from causes and an the date stated above FUNERAL DIRECTOR: 22o. SIGNATURE 22b DATE SIGNED STAFF PHYS. DIRECTOR July 26, 1967 M.D. un 22d ADDRESS 22c. PHYSICIAM'S NAME (Type) **JACOBSON** CUMBERLAND, MD. 23c NAME OF CEMETERY OR CREMATOR 23d LOCATION (City or Town) 230 BURIAL, CREMATION ((ounty) (State) 24 FUNERAL DIRECTOR REC D BY REGISTRAR



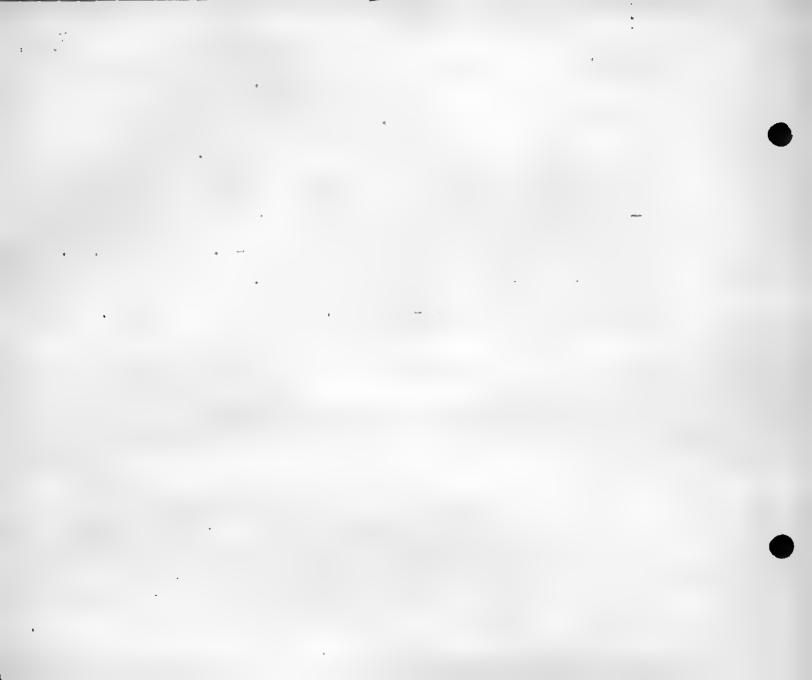
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08868 08969 CERTIFICATE OF DEATH requires that the death certificate be executed-within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY ALLEGANY MARYLAND ALLEGANY MARYLAND within 72 hours off b. (ITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) CUMBERLAND CUMBERLAND DAYS d. STREET ADDRESS 323 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) popers. IS RESIDENCE ON A FARM? ed MEMORIAL HOSPITAL NO TO NAME OF First Middle Lost 4 DATE Month DECEASED OF EARL SPARKS JULY 19 67 LDA (Type or print) DEATH SEX IF UNDER 1 YEAR 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove last Thoday) Months WHITE FEMALE and in ony WIDOWED DIVORCED 10b KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY ? during most of working life even if retired) ottending physicion of sermit. Then please PENNSYLVANIA HOME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, LAVINA BATZEL **半期世色男本学男男我們** MIRAM ROHM 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no on unknown) (If yes give war or dates of service permit. 208-07-0850 CUMBERLAND. MD. MEMORIAL HOSPITAL. cremation. TB. CAUSE OF DEATH (Enter only one couse per time for (a), (b), and (c).)
PART 1, DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-tronsit ONSEL AND DEATH DUE TO burial. Conditions, if any, which gove (b) rise ta immediate cause (a), DUE TO stoting the underlying couse be retained by the hospital or ottending as the last WAS AUTOPS hos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES NO 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form 20c. TIME OF INJURY Month, Doy, Year (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Not While of work 21. 1 certify that (1) (this hospital) attended the deceased from\_ 19.8 . 2 % P. M. 19\_\_\_, that (I) (we) lost M, fram causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceased alive on and that deoth accurred at 22a. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D. DIRECTOR PHYS 22c. PHYSICIÁN'S CUMBERLAND, MD. LANE SCHINDLER В NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23a. BURIA., CREMATION 23d. LOCATION (City or Town) (County) R.D.2.EVERETT REGISTRAR VR A15 (4)-25M 1/67 W. MAIN . FROSTBURG . MD . DATE



1-4	MARYLAND STATE I  Division of STATISTICAL RESEARCH AND RECORDS,	DEPARTMENT OF HEALTH 301 W. PRESTON STREET, BALTIMORE, MARYLAND	21201
	OR970 CERTIFICA	TE OF DEATH	08969
ampletely filled in by the funeral ve carban papers. Pages 1 and 2 event, within 72 hours after degrate.	1. PLACE OF DEATH 0. COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (Where deceosed lived, if institution: Reso. STATE Md. b. COUNTY A	sidence before odmission) 11egany
urs aft	b (ITY OR TOWN (If outside corporate limits,  we'rite RURA, and give nearest town)  westernport  6 Mone	c CITY OR TOWN (If outside corporate limits, write RURAL and	give necrest town)
00	d NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street oddress)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	503 Roberts St.	90 Doughlas Ave.	YES NO X
	3 NAME OF First Middle PECEASED (Type or pnnt) Lucille Eleanor	STAKEM OF STAKEM	20 19 67
	S SEX   6. COLOR OR RACE   7 MARRIED   NEVER MARRIED	8. DATE OF BIRTH  9. AGE (in years lost birthday)  11ay 10, 1911  56 yrs	hs Doys Hours Min.
	100 USDAL OCCUPATION (Give kind of work done during most of working life, even if retired)  100 KIND OF BUSINESS OR INDUSTRY	Allegany-Md.	2. CITIZEN OF WHAT COUNTRY? U.S.A.
	Robert F. Mitchell	14. MOTHER'S MAIDEN NAME	
	TS WAS DECEASED EVER IN ILS ARMED EDROES? LIA SOCIAL SECURITY NO. 12	Mary S. Spiers  Modress	
	(Yes no or unknown) (If yes nive wor or dates of service)	irs. June Brown-Westernport. M	ď.
	1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (c)	scular Collarse	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave rise to immediate cause (a),	Ca of Overy with	J April/66
	stating the underlying couse (c)	Melaslasis	1 July 27/6
2	PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED T		19. WAS AUTOPSY PERFORMED? YES NO
	200 ACC DENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Month, Day, Yeor Hour a m.  201. Not While Not While	D (Enter nature of injury in Port I or Part II of item 18.)	
	20c. TIME OF INJURY Month, Day, Yeor Hour a m. P.m. 19 20d. INJURY OCCURRED While of work of work	PLACE OF INJURY (Home, form, actory, street, office bldg., etc.)	(County) (State)
	The state of the s	hat death accurred atM, fram tauses and c	19 , that (4) (we) las on the date stated abave
	220 SIGNATURE Dalde M.D	M.D. PHYS DIRECTOR PHYS	6. DATE SIGNED /67
1	22c. PHYSICIAN'S AMERICO Valdes	226 ADDRESS HLEGONGUINHOTE	Cumberland
	230 BURIAL (REMATION, PRINCIPLE 230 DATE THEREOF 230 NAME OF CEMETERY CONTROL OF CEMET		(County) (State)
1	24 FIMIFPAL DIRECTOR / ADDRESS	250. REC'D BY REGISTRAR ASS REGISTRA	Md.
3	Westernport,	Md. JUL 2 5 196/	and him



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH USUAL RESIDENCE Where deceased lived. If Institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY ALLEGANY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) s. Pages hours afte b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town) hours 22HRS., 45 MIN Ξ CUMBERI AND CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? WITHIN SACRED HEART HOSPITAL YES NO Y 1216 etery 3. NAME OF First Middle DATE Month Last DECEASED remove carb n any event, y (Type or print) INA DEATH STEWART 19 Com executed 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED F in any i апф WIDOWED K FEMALE WHITE DIVORCED [ 10a, USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT BIRT APLACE (County & State, or foreign country) ease death certificate be during most of working life, even (f retired) INDUSTRY COUNTRY? COOK RESTAURANT TUCKER CO... W. VA II.S A ᅙ 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending ph ermit. Then remova JAMES 01va White 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. 5 SETON DRIVE (Yes, no, or unkown) [(If yes give war or dates of service) NO 220-16-6038 RECORD ERLAND, MD. 21502 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN that the al-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: physician. IMMEDIATE CAUSE (a) signed DUE TO Conditions, If any, which gave rise to Immediate 후로 DUE TO cause (a), stating the prior underlying cause last. CERTIFICATION PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED WAS AUTOPSY for use Health certificate PERFORMED? YES 🗍 NO PHYSICIAN: 20a. ACCIDENT WAS UNDER THIS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) tached f Dept. of | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) det factory, street, office bldg., etc.) Hour a.m. Not While While p.m. at work at work be retained should 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: Jage 3 should lifed with the 🟒 that (I) (we) last saw the deceased alive on and that death occurred at a SEM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED page ATTENDING? PHYS DIRECTOR Page 4 may O HOSPITAL FUNERAL PHYSICIAN'S 22c. ADDRESS director, p should be 1 NAME (Type) PAGAN POTOMAC STREET, RIDGELEY, W. BURIAL, CREMATION, 23b. 23a. DAY'E THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) Cumberland. Burial Herman Cemetery Md. 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. SILCOX FUNERAL HOME 404 DECATUR ST. VR AI5 (4) 1/65



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08971

FOR STALE HEALTH DEP Page any delay is and 3 ta

Depart

Page 4 shauld be forwarded to the Chief Medical Examiner's Office along with form

necessary, please execute the certificate writing the word "pending"

TO DEPUTY MEDICAL EXAMINER:

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages land 2 with the Stark

Health prior to burial, cremation, or remaval, and in any event within 72 hours after death

n pencil in Item 18. Give Pages 1,

This certificate shauld be executed within 24 haurs after death

00079

## MEDICAL EXAMINED'S CERTIFICATE OF DEATH

U031	16	MEDIC	AL LAMITHIEK J	CERTIFICATE	OF DEATH		
1 PLACE OF DEAT	H			2 USUAL RESIDEN	CE (Where deceased lived,		ce before odmission)
a COUNTY	Allegany		MARYLAND	o STATE (A	. Va.	b COUNTY MA	ineral C
b CITY OR TOW	M /If ou to de corporate limit		C LENGTH OF STAY N 16	c CITY OR TOWN (	It outside corporate limits,	write RURAL and give	e nearest tawn)
write RURAL	and eve negrest town)			Rt. #	1 Ridgeley.	phy	
d NAME OF HD!	P TAL DR INSTITUT DN (fine	ot in hospital give	e street address) Cumb.	d STREET ADDRESS		./ .	e IS RESIDENCE
Along	U. S. Rt. #	40, 4 m	i. East of	Along	St. Rt. # 2	8	YES NO X
3. NAME OF DECEASED	F	rst	Middle	Last	4 DATE OF	Month	Day Year
(Type or print)	Lar		Raymond	VanMeter	DEATH	July 22	
S SEX	6 CDLOR OR RACE	7. MARRIED 🛛	NEVER MARRIED	B. DATE OF BIRTH	9. AGE (II	rthday) Months	Doys Hours Min
Male	White	MIDOMED	DIVORCED	March 2,	1943   24	yrs	
10o. USUAL OCCUPAT	ON (Give kind of work done ing life, even if retired)	10b KIND	DE BUSINESS DE Glas		tote or foreign country)	12 (1	IZEN DE WHAT
Lab	orer	Pitts	burgh Plate	Cumber			UNJRY? S. A.
13. FATHER'S NAM				14 MOTHER'S MAII			
	W. VanMeter			Virgin	ia E. Lease		
15 WAS DECEASED	EVER IN U.S. ARMED FORCES?	16. SO(		INFORMANT		Address	
yes,	n) (If yes a ve war or dates of	218	-40-3241 Mz	. Ray W. V	anMeter, Cri	esaptown,	Md.
	DEATH (Enter only one cou	se per ne for (a					INTERVAL BETWEEN
PARI I 3	PEATH WAS CAUSED BY, IMMEDIATE CAUSE	(o)	Hemoth	norax, Bil	lateral		Minutes Minutes
7 71	, , , , , , , , , , , , , , , , , , , ,	TO	(7)		m		0.11
Conditions fo	inte couse (o),	(b)			Thoracic Spi		Sudden
	iderlying couse DUE	TO	and po	sterior f	racture of I	libs.	
lost	)	(c)					
PART I OTHER	SIGN FICANT CONDITIONS C	ONTRIBUTING TO	DEATH BUT NOT RELATED TO	THE TERM NAL DISEASE	CONDITION GIVEN IN PAI	(T 1(a)	PERFORMED? YES Y NO
200 EXTERNAL	CAUSE WAS CONTRIBUTING []	20b DESCR	RIBE HOW INJURY OCCURRED	(Enter noture of injur	y in Port I or Port II of ite	m 18.)	
		Drive			Le motorcyc]		t.
= -	NJURY Month Dov. Year	20d INJU	IRY OCCURRED 20e PL	ACE OF NJURY (Home	form, 20f (City or	town) (Cou	unty) (State)
Mont.	pm July 22 19	67 While of work	Not While Rt. fo	#40, 4 mi	les East, Cum	berland, A	lleg. Md.
21. I cer			ıns descr bed abave, h				
death re	sulted fram: Natura	al causes	Accident X Su	cide 🔲, Hami	ride Undetern	nined manner 🗌	
ACTUAL	0 .	· Va	1- 11	CHIEF MED	ICAL EXAMINER		
SIGNATURE >	Dene feat	- Skil	arelie	111. L/	MEDICAL EXAMINER		22. DATE SIGNED
EXAMINER'S	DENTEDTOR	, -		DEPUTY M	EDICAL EXAMINER 🔀 🕻	uly 22, 1	967
NAME (Type)	BENEDICT S			Address (	freet, city, lower or county	Cumberlan	d, Maryland
230 BURIAL, TREM. REMOVAL (Soc			23c NAME OF CEMETERY OF		23d LOCATION		(County) (State)
		101	Restlawn Mem	orial Gard	ens Cumber	Land, Alle	gany, Md.
24 FUNERAL D RE		Country a + D -	ADDRESS		RECD BY REGISTRAR  JUL 2 6 196		co judge.
n. wal	ine George (	umberca	na, ma.	DATE	AAF TO 100	1	0

VR A15ME (5) 6M 1/67

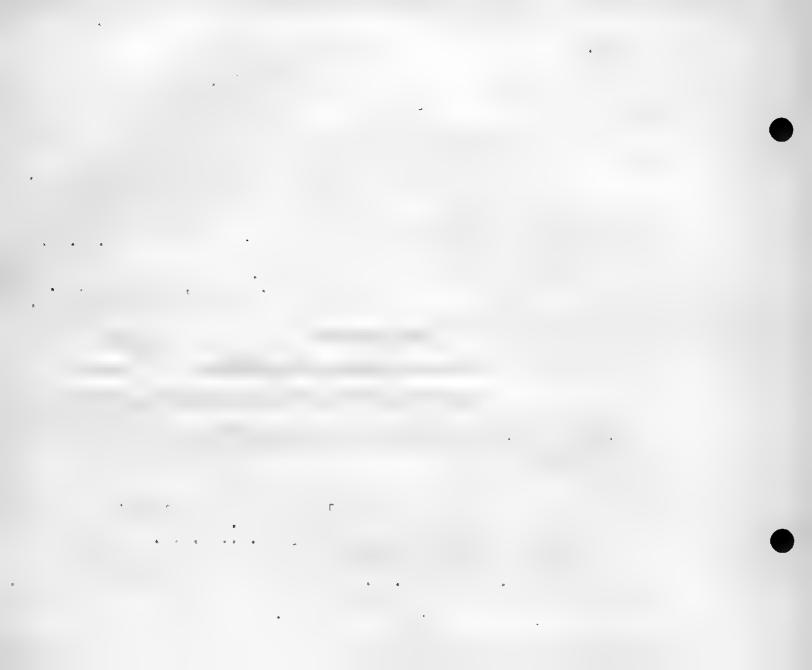
5 may be retained for your files.

the funeral director.

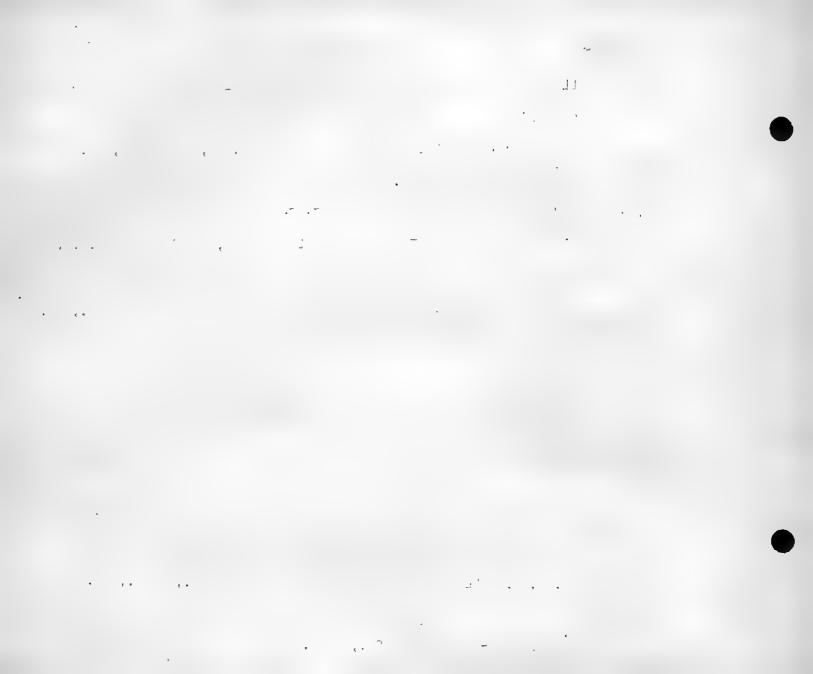
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 08973 requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission filled in by the funeral papers. Pages 1 and PLACE OF DEATH o. COUNTY Allegany b. COUNTY Marydand legany MARYLAND b CITY OR TOWN (If autside corparate limits, write RURAL and give negrest town)

Cumberiand CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate simits, write RURAL and give nearest tawn) 1963 Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS 156 Frederick Street Allegany County Infirmary NO X NAME OF 4 DATE Middle Year DECEASED Lester Wade July 67 Wilbur 19 (Type or print) DEATH AGE ( n veors IF JNDER 24 HRS 6 COLOR OR RACE NEVER MARRIED DATE OF BIRTH 7. MARRIED please remove Last birthdoy) Hours Male White 1/3/1892 burial, cremation, or removal, and in any WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11, BIRTHPLACE (Caunty & State, or fareign country) 12 CITIZEN OF WHAT dur ng most of working life, even if retired)

Retired: Painter Frostburg. Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Owen Herse Wade Nora E. Rice 17. INFORMANTP.O. Box 599, Cumider Land, Md. 21502 1S WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (1f yes give war or dates of service 16. SOCIAL SECURITY NO. Allegany County Infirmary records. INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) burial-transit ONSEL AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gove rise to immediate cause (a) DUE TO stating the underlying couse be detached for use as the State Dept. of Health prior to lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) has NO O FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for us 205. DESCRIBE HOW INJURY OCCURRED (Enternature of injury in Part I or Part II of item 18.) 20g ACC DENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or tawn) (County) (Stote) 20c TIME OF INJURY Manth, Day, Year Haur o.m. foctory, street, office bldg., etc.) Not While at wark at work to 7/21/196/19\_\_\_, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased from 1/18/ 7/21/196719 , and that death accurred at  ${f P}_ullet$ M. from causes and on the date stated abave saw the deceased alive an. D.S.T.
STAFF
PHYS. 22b. DATE SIGNED 22o, SIGNATURE DIRECTOR X director, page 3 should be filed v 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) John A. Topper, Memorial Hospital, Cumberland, Md. 23d. LOCATION (City of Town) (State) 23a BurlAL, CREMATION, (County)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 3897 requires that the death certificate be executed within 24 hours after death. and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE **b.** COUNTY ALLEGANY MARYLAND MARYLAND ALLEGANY campletely filled in by the land carban papers. Pages yevent, within 72 hours after b. CITY OR TOWN (If outside carporate limits. CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) FROSTBURG CUMBERLAND DAYS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? carban pap SACRED HEART HOSPITAL FROSTBURG YES NO D NAME OF Middle First Lost 4. DATE Month Rose Year DECEASED WALKER (Type or print) 20 67 Marie DEATH 19 S SEX IF UNDER 1 YEAR I IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** B. DATE OF BURTH 9. AGE (in years birthdoy) Months remak Hours 3-17-21 WHITE WIDOWED DIVORCED FEMALE signed by the attending physician and burial-transit permit. Then please rem 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
BEAUTICIAN COUNTRY? SALON CLARYSVILLE, MARYLAND 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME ar remayal BERNARD MARTIN DELANEY HILDA MARTIN 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) 900 SETON DR. HOSPITAL RECORD 216-18-1629 CUMB. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY CONST AND DEATH CERRBRAL VASCULAR ACCIDENT IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a), **DUE TO** stoting the underlying couse attending this certificate has been 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) ACVD BRONCHIAL ASTHMA NO X O HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital ar 20o ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work 19. 1967, that (I) (we) last 21. I certify that (!) (this haspital) attended the deceased fram 3 1955 . ta - 1919 and that death accurred at 1 A M, from causes and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an 22o SIGNATURE 22b DATE SIGNED STAFF PHYS. 7-20-67 DIRECTOR M.D. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S 62 GREENE ST., CUMB., MD. 21502 NAME (Type) DR. R. W. BALLIN 23a. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 7/22/67 St. Michael's Cemetery Frostburg Allegany Maryland 24. FUNERAL DIRECTOR H. Lee Silcox ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 SILCOX FUNERAL HOME-404 DECATUR ST., CUMB. (Charles &

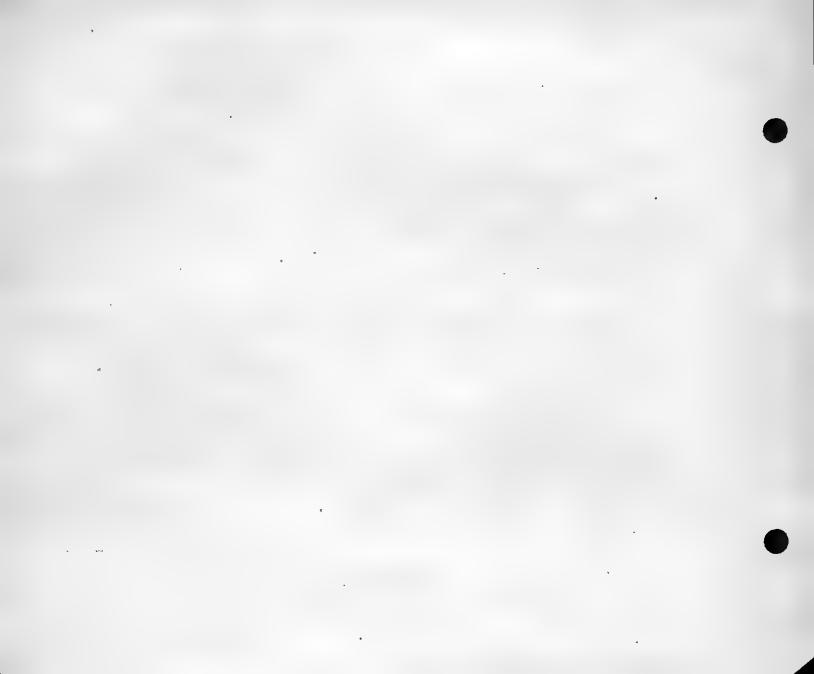


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 98075 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY a. STATE b. COUNTY oon papers. Pages 1 within 72 hours after Allerany Allegany MARYLAND Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Cumberland 40 years Cumberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS filled arch Street NO X and committeely remove carbon ! NAME DE Month First Middle DATE Last DECEASED any event, DEATH (Type or print) Johanna 14 19 67 Weimer July executed SEX 6. COLOR OR RACE I 8. DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. | Iast birthday) | Months | Days | Hours | Min. 7. MARRIED - NEVER MARRIED Ferale White WIDOWED [ DIVORCED [ 80 yrs. Au. ust 10a, USUAL OCCUPATION (Give kind of work done ! lease re and in 106. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) been signed by the attending physician the burial-transit permit. Then please in or to burial, cremation, or removal, and in death certificate be during most of working life, even if retired) COUNTRY? Home Housewife Own Connellsville 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles F. Fannie 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) Mrs. Gladys Mock, Cumberland, Md. Daughter 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Acute coronary occlusion minutes the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic cardiovascular disease. Conditions, if any, which gave rise to Immediate DUE TO (a). stating r this certificate has b detached for use as t te Dept, of Health prior underlying cause last. (c) WAS AUTOPSY CERTIFICATION 19. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO IX YES [ DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part |) of Item 18.) 20a. ACCIDENT WAS UNDERLYING F OR CONTRIBUTING ( CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) 20f. (City or town) (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, TO HOSPITAL OR ALL.

Page 4 may be retained by

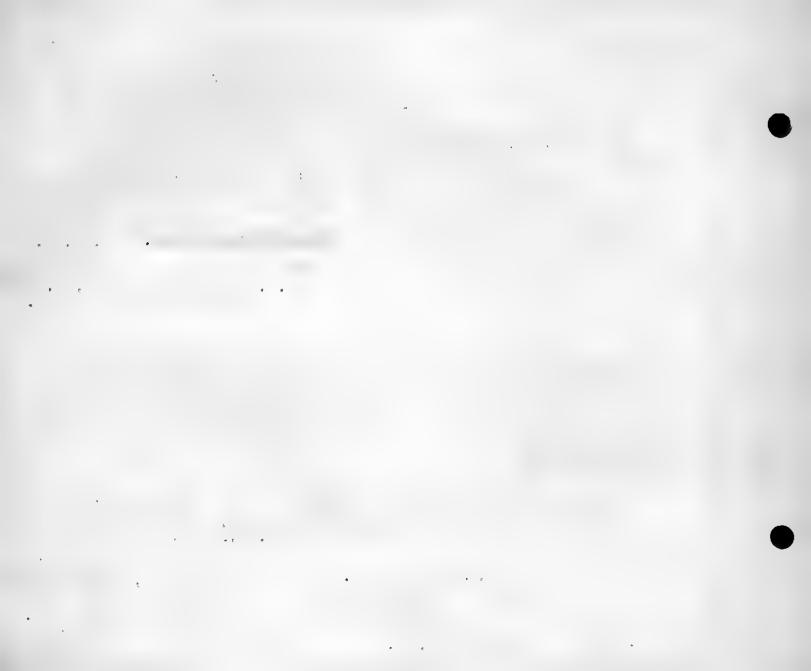
THE FUNERAL DIRECTOR: After the

Light page 3 should be defended by the State factory, street, office bidg., etc.) be de State Hour a.m. While Not While at work! at work p.m. to July 21. I certify that (I) (this hospital) attended the deceased from Oct. \_ 19\_67\_ that (I) (we) last 196] saw the deceased alive eff\_ and that death occurred at.... \_M. from the causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE MED. 7-17-67 STAFF PHYS. 22d, ADDRESS PHYSICHAN'S Himmelwright 133 Virginia Ave. Cumberland Md M.Dl. .G. Overton 23d. LOCATION (City, town or county) (State) 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. REMOVAL (Specify) Hillcrest Burial Buria Cumberland. 24. FUNERAL DIRECTOR ADDRESS arpelli. Cumberland. VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08975 08976 CERTIFICATE OF DEATH deon. requires that the death certificate be executed within 24 hours after death PLACE OF DEATH funera 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Allegany COUNTY b. COUNTY Maryland Allegany **MARYLAND** ers Pages 2 hours afte b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland c LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? the ottending physicion and completely filled, sit permit. Then please remove corbon page Allegany County Infirmary 17 Valley Street YES NO K 3 NAME OF **D FUNERAL DIRECTOR:** After this certificate hos been signed by the oftending physicion and completely functor, page 3 should be detoched for use os the buriol-transit permit. Then please remove corban should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, with First 4 DATE Dov Year DECEASED (Type or print) Belle Gussie Welsh July 25 67 DEATH 19 5. SEX 6 COLOR OR RACE 9. AGE (In years DATE OF BIRTH IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours Female White WIDOWED X DIVORCED 10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSOWII KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Own home Bedford County, Penha 13 FATHER S NAME 14. MOTHER S MAIDEN NAME Emanuel Valentine Beble Rice IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 (Yes, no, or unknown) (If yes give wor or dates of service Allegany County Infirmary records. None No 18 CAUSE OF DEATH (Enter only one couse per PART I DEATH WAS CAUSED BY ne for (o), (b), and (c) ) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) be retoined by the hospital or attending physicion. DUE TO Conditions, if any, which gove nse to mmediate couse (o), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) WAS AUTOPSY PERFORMED? NO DO 20o. ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20s PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (City or town) (County) (Stote) 0 Hour am factory, street, office bldg., etc.) While of work L ot work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram April , 19 65, to July 25, 19 67, that (1) (we) last 1967, and that death occurred at A. M, fram causes and an the date stated above. saw the deceased alive an July 220. SIGNATURE 22b. DATE SIGNED DIRECTOR XX PHYS M.D PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D. Memorial Hospital, Cumberland, Md. 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 7/27/67 Zion Memorial, Park Cumberland. Allegany Md. 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE VR A15 (4) H. Wayne George Cumberland, Md. 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 2, and Page o COUNTY o STATE b. COUNTY Allegany Mary land Allegany MARYLAND b CITY OR TOWN (foutside corporate limits write RURA, and give nearest town)

Cumberland c LENGTH OF STAY IN 1b c CIY OR TOWN (1 autside carparate imits write RURAL and give nearest town) 2 HRS. Mt. Savage d NAME OF HOSPITAL OR INSTITUTION (I not in hospital give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? form CHURCH HILL hou Sacred Heart Hospital NO A Grve Poges YES | 24 hours ofter deoth Office along with NAME OF 4 DATE Lost Month Day Year DECEASED 16 67 July Williams Nondas with the (Type or print) Mary 10 DEATH IF UNDER I YEAR 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdoy) Months in Item 18 6-16-05 WIDOWED event White DIVORCED Female 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 12 CT ZEN OF WHAT during most of working life, even if retired) IND..STRY MARYLAND poges 1 Chief Medical Examiner's Housewife pencil 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within EDWARD FANNON ANNE FARRELL ond 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address permit. (Yes, no, or unknown) (If yes give war or dates of service) remayal. DANIEL WILLIAMS, MT. SAVAGE, MD. 18 CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY Cerebral Hemorrhage 10 IMMEDIATE CAUSE (o). This certificate should e, writing the ward forwarded to the Ct cremotion, DUE TO Hypertensive Cardiovascular Disease Conditions, if any which gave nse to immediate couse (a), DUE TO stoting the underlying couse burial, o lost PART II OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19 WAS AUTOPSY PERFORMED? NO X please execute the certificate, 20o EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of mury in Port I or Port II of term 1B.) PRIMARY ... or CONTRIBUTING ... should CAUSE OF DEATH 20e PLACE OF NJURY (Home, form, 20f (City or town) (County) (State) 20c TIME OF INJURY Month Dov. Year 20d NJURY OCCURRED foctory, street, office bidglietc) Not While moy be retoined for your FUNERAL DIRECTOR: Page at work at work designated 2). I certify that I taak charge of the remains described above, held an Autopsy ... Inspection XI, Inquity X and in my apinion death resulted fram Accident . Suicide . Hamicide Undetermined manner the funeral director Natural causes 12-12 CHIEF MEDICAL EXAMINER 5 moy be reto TO FUNERAL DI Health or its d 22 DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE \_ TO DEPUTY July 16, 1967 DEPUTY MEDICAL EXAMINER X **EXAMINER'S** BENEDICT SKITARELIC. M.D. Address (Street, city, town, or county) Cumberland, Maryland NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o BURIAL CREMATION. 236 DATE THEREOF BURTAL (Specify) ST. PATRICKS CEMETERY MT. SAVAGE, MD. 250 REC'D BY REGISTRAR 256 REGISTRARS SIGNATURE 24 FUNERAL DIRECTOR VR A15ME (5) JOSEPH R. DURST, SR., FROSTBURG, MD.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY b. COUNTY 11emany o. STATE Allegany MARYLAND on papers. Pages 1 within 72 hours after CLENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural vesternport Yrs Rural Westernport requires that the death certificate be executed within 24 haug d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) . ⊆ d. STREET ADDRESS e IS RESIDENCE ON A FARM YES X NO on campletely fi 3 NAME OF First Middle 4 DATE Lost Month Day Year DECEASED Wilson OF DEATH July Olyde Ernest 67 (Type or print) S SEX 6 COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED SEL 8 DATE OF BIRTH **NEVER MARRIED** (yobitrid teal Months Doys Hours Male White June 10, 1906 WIDOWED DIVORCED signed by the attending physician and burial-transit permit. Then please rem burial, crematian, ar removal, and in da 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Stock Washer Paper Mill COUNTRY 2 Allegany-Md. 13. FATHER'S NAME 14. MOTHER S MAIDEN NAME Anna Whitesell Harry S. Wilson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Olara Wilson -Westernport. Md. 217-05-1113 no INTERVAL BETWEEN / 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c))
PART I. DEATH WAS CAUSED BY. AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse the has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? CERTIFICATION USe YES 🗔 NO TO FUNERAL DIRECTOR: After this certificate far 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED (City or town) TIME OF INJURY Month, Day, Year 20e, PLACE OF INJURY (Home, form, (County) (State) Hour o.m. Not While factory, street, office bldg., etc.) of work of work . 19 6 . (that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from Page 4 may be retained director, page 3 shauld shauld be filed with the saw the deceased alive an 19 6 Sand that death accurred at M. flom causes and an the date stated above. SIGNATURE 22b. DATE SIGNED MED ATTENDING M.D. DIRECTOR PHYS. PHYS. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230. BURIAL, (REMATION, BRAND AND ADDITION) (Stote) (County) Philos Westernport, Md. FUNERAL DIRECTOR ADDRESS BY REGISTRAR VR A15 (4) 20 M 1/66 Westernport, Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 38978 CERTIFICATE OF DEATH The taw requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY **ALLEGANY** MARYLAND WEST VIRGINAA b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH DE STAY IN 16 c CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) **36** HOURS 60 RIDGELEY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS SACRED HEART HOSPITAL 43 CENTRAL AVE. YES NO TX NAME OF First Middle Lost 4 DATE Dov Year DECEASED **ODESSA** WILSON JULY FAY 29 67 (Type or print) 19 DEATH S SEX 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED birthdoy 2/3/02 burial, cremation, or removal, and in ony FEMALE WHITE WIDOWED DIVORCED 100 LSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
HOUSEWIFE INDUSTRY U.S.A. STRAUSBURG, VA. 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME WILLIAM SHANK Kathryn Howe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ar unknown) (If yes give wor ar dotes of service) 217-10-7590 HOSP, RECORD SACRED HEART HOSPITAL IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriof-tronsit PART - DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse as the Page 4 may be retained by the hospital or ottending PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? 200 ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) FUNERAL DIRECTOR: After this (County) (Stote) factory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this haspital) attended the deceased fram. . 1967, ta 196 7, that (1) (we) last 19 6 7, and that death accurred at 9 M, fram causes and an the date stated above. saw the deceased alive an 220 SIGNATURE DATE SIGNED DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS MINERAL COUNTY O HOSPITAL NAME (Type) 5 POTOMAC ST director, should be RIDGEL 230 BUR AL, CREMATION 23c NAME OF CEMETERY OR CREMATORY DATE THEREOF 23d LOCATION (City or Town) (County) REMOVAL (Specify) Davis Memorial Park Cumberland, Md. All 0 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR James F. Scar, elli, Cumberland, Md. DATE AUG 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 68979 28980 CERTIFICATE OF DEATH 24-hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY a. STATE b. COUNTY ALLEGANY MARYLAND MARYLAND ALLEGANY b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) CLENGTH DE STAY IN 16 c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE CUMBERLAND 12 HRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE d STREET ADDRESS ON A FARM? YES NO [ SACRED HEART HOSPITAL requires that the death certificate be executed within NAME OF 4 DATE Last Month Dov Year DECEASED (Type or pont) CHARLES W. WINEBRENNER JULY 29 67 DEATH 19 S SEX 6 COLOR OR RACE 9 AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED B. DATE OF BIRTH **NEVER MARRIED** Months MALE WHITE 3-22-07 MIDDWED DIVDRCED 10o USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

JAN ITOR 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) **CDUNTRY?** INDUSTRY MT. SAVAGE, MD.

14 MOTHER'S MAIDEN NAME CELANESE CORP II S A 13. FATHER'S NAME STEWART WINEBRENNER WINEBRENNER MARY (WINEBRENNER) 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) 220-10-9393 HOSPITAL RECORD 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (0) CERE BRAL WEMDER AGE DUE TO Conditions, if ony, which gove ) 104,85 UPERTENSION rise to immediate couse (a), **DUE TO** stoting the underlying couse C FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) ND [ YES 🗌 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of Item 18.) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY DCCURRED 20e. PLACE OF INJURY (Home, form 20f (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While at work 21. I certify that (1) (this haspital) attended the deceased fram 2-29, 1967, ta 7-29, 1967, that (1) (we) last saw the deceased alive an 2-2, and that death accurred at 30 M, fram causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) DRS. GLICK, SPIGGLE & VINCENT 126 N. SMALLWOOD ST., CUMB., MD. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230. BURIAL CREMATION, (Stote) REMOVAL (Specify)
BURLAL METHODIST CEMETERY MT. SAVACE. 8-1-67 2So REC D BY REGISTRAR 256 REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 156 PROSTBURG, MD. 25M 1/67 DURST FUNERAL HOME



A	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY	/LAND
FOR STATE	U8981 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	18920
HEALTH DEPT.	1. PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived, If institution, Resident	nce before edmission
学》(章)	o. COUNTY Allegany  MARYLAND  o. STATE Maryland  b. COUNTY Allega	
SS	b. CITY OR TOWN (if outside corporate limits.   C. IFNGTH OF STAY IN 15 CITY OR TOWN (if outside corporate limits.	· ·
nac ecto rour of	write RURAL and give neerast town)  Mt. Savage  Mt. Savage	11.1
is dir	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street eddress)  d. STREET ADDRESS	. IS RESIDENCE
funeral funeral fined f fined f fate Bo		YES NO THE
E 2200	3. NAME OF First Middle Last 4. DATE Month Day	
the stretch	(Type or print) Shannon V. Wright DEATH July 4, 1967	19
d 3 to d	5. EX   6. COLOR OR RACE 7. MARRIED   NEVER MARRIED   B. DATE OF BIRTH   19. AGE (In years 1 If UNDER 1 YEAR	
and and 2 w	Male White WIDOWED DIVORCED February 23, 1900 67 VF. Months Days	Hours Min.
affe 2,2,2,2,3,2,2,2,2,2,2,2,2,2,2,2,2,2,2,2	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)  10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  12. CITIZEN (	OF WHAT COUNTRY
Pag Pag s 1 s	Truck driver Trucking Chaneysville, Pa. USA	
Pag A3.	13. FATHER'S NAME	
A PA	James W. Wright Emma Ruby	
PVe F	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address  (Yas, no, or unknown)   (Ifyasgivawarordelasofservice)	
or y lith	NO 191-07-5037 Mrs. Velma Wright, Mt. Savage, Mar	ryland
in the state of th		TERVAL BETWEEN
cil ii	PART I. DEATH WAS CAUSED BY: CORONARY OCCLUSION	UDDEN DEATH
d be id-fi	9 AD DUE TO	
Por in	Conditions, if eny, which CORONARY SCLEROSIS	-
12 S S S S S S S S S S S S S S S S S S S	geve rise to Immediate cause (a), stelling the underlying DUE TO	
fical min ed a	couse lest. [c)	
Exa Exa e us	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6)	19. WAS AUTOPSY PERFORMED?
his wor	3	YES NO
Aed hould	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)  20s. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING DESCRIBE HOW INJURY OCCURED. (Enter neture of Injury in Part II or Part II of item 18.)  CAUSE OF DEATH.	
ing		
Chine Chine	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County)  Hour a.m. While Not While fectory, street, office bldg., etc.)	(State)
io. P. F.	Petros ry I hand panel	
To T		in my opinion
Sent dec	death resulted from: Natural causes X, Accident . Suicide . Homicide . Undetermined manner	
TY I. J. Control of the control of t	CHIEF MEDICAL EXAMINER	
at for the	SIGNATURE AND M.D.	DATE SIGNED
execute find be forw	EXAMINER'S DEPUTY MEDICAL EXAMINER X JULY 4, 1967	
DEPUTY Nease execute should be to PUNERAL. its designair	NAME (Type) BENEDICT SKITARELIC, M.D. Address (Stree), city, town, or county MAI  220. BURIAL, CREMATION, 22b. DATE THEREOF   22c. NAME OF CEMETERY OR CREMATORY   22d. LOCATION (City, town, or country)	(Stote)
O 240 9 O 842 744	REMOVAL (Specify)	***************************************
HHH	Burial July 8, 1967 Rest Lawn Memorial Garden's Cash Vly. Rd., La Vale	Mad
VS. A15ME A	111 1 1 1967 Williams	
m 2100 B) 1 d	Hyndman, Pennsylvania DATE OUL 10 1001	1

MARYLAND STATE DEPARTMENT OF HEALTH

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